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ABSTRACT

This annual report reviews the work UNICEF has been doing to help transform the "Child Survival Revolution" from a dream into a reality. Discussion focuses primarily on child health and nutrition and other basic services for children. Throughout, the review is supplemented with profiles of program initiatives made to improve the conditions of the poor in developing countries. Colombia's primary health care services to people in the mountainous Cauca Department are profiled along with examples of programs designed to reduce infant morbidity and mortality in Zimbabwe, the Congo, the Philippines, and Indonesia. Discussion of other basic services for children concerns safe water supplies and sanitation (profiles from Nigeria and Burma); formal and nonformal education (profile from Bangladesh); urban basic services (profile from Brazil); women's activities (profile from Costa Rica); appropriate technology (profile from Nepal); and childhood disabilities. Discussion further concerns program support activities, advocacy for children, and emergency relief and rehabilitation (profile from Ethiopia). The review concludes with a map showing UNICEF program commitments in the developing world. Supplementing the review are charts; a map; tables indicating UNICEF's finances in terms of income, commitments, and expenditure for 1983-84; and a brief overview of UNICEF's philosophy, policies, methods of program cooperation, and supporting activities. (RH)

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1984

UNICEF Annual Report

Contents

Introduction by the Executive Director, James P. Grant	3
--	---

UNICEF 1983-84: a review	5
--------------------------------	---

Highlights of the year's programme co-operation, including trends and key events, illustrated by specific programme profiles from different countries.

Child health and nutrition	7
----------------------------------	---

Primary health care	7
---------------------------	---

Profile: "G" is for "growth" (COLOMBIA)	8
---	---

Towards a revolution in child survival	10
--	----

Profile: "Forward with the prevention of diseases" (ZIMBABWE)	11
---	----

Profile: Breast and bottle (CONGO)	13
--	----

Profile: They thought one shot was surely enough (PHILIPPINES)	15
--	----

Profile: The "midhusbands" of Bali (INDONESIA)	16
--	----

Child Nutrition	17
-----------------------	----

Other basic services for children	19
---	----

Safe water supplies and sanitation	19
--	----

Profile: Spreading the good news about water and sanitation (NIGERIA) ..	20
--	----

Profile: "We need water, not gold" (BURMA)	22
--	----

Formal and non-formal education	23
---------------------------------------	----

Profile: The clay-pot savings scheme (BANGLADESH)	24
---	----

Urban basic services	25
----------------------------	----

Profile: A sense of comradeship (BRAZIL)	28
--	----

Women's activities	30
--------------------------	----

Profile: Crocheting may not be the answer (COSTA RICA)	31
--	----

Childhood disabilities	32
------------------------------	----

Appropriate technology	33
------------------------------	----

Profile: Sushila needs a new kitchen stove (NEPAL)	33
--	----

Programme support activities	34
------------------------------------	----

Advocacy for children	36
-----------------------------	----

Emergency relief and rehabilitation	39
---	----

Profile: Seeing it coming just wasn't enough (ETHIOPIA)	40
---	----

Map: UNICEF in action: programme commitments in the developing world ..	26
---	----

UNICEF's finances: income, commitments, and expenditure 1983-84	43
---	----

Chart: UNICEF income 1979-84	43
------------------------------------	----

Map: 1983 governmental contributions	44
--	----

Table: 1983 non-governmental contributions	46
--	----

Chart: UNICEF income, by source	46
---------------------------------------	----

Chart: UNICEF expenditures 1979-84	47
--	----

Charts: UNICEF expenditures on programmes by sector 1979-83	48
---	----

What UNICEF is and does	49
-------------------------------	----

An overview of UNICEF's philosophy, policies, methods of programme co-operation, and supporting activities.

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Introduction

by the Executive Director, James P. Grant

This past year has undoubtedly been the most exciting of the four years which I have served as UNICEF's Executive Director. That excitement has come from a growing sense that, despite the terrible economic conditions that continue to afflict many countries and the lives of millions of people, *children still have a chance.*

That chance for children is not just to survive, but to grow in health as productive, self-reliant human beings.

My belief that this possibility exists has gradually strengthened despite many grounds for pessimism. After all, these past four years have brought a near complete reversal to the positive development trends which had characterized the previous three decades. Many of us will remember that 1979, the International Year of the Child, was celebrated in an atmosphere of optimism and renewed dedication to the cause of children and childhood everywhere.

That note of promise quickly faded. Before the decade began, the World Bank predicted that the absolute number of the world's poor would decline; two years into the decade, the United Nations forecast, that, instead, the numbers of absolute poor would increase from 800 million to one billion by the decade's end. Infant mortality rates had been on the decline. But all the signs are that in certain areas more children died this past year than the year before, and in some parts of Africa, the numbers appear to have increased substantially.

In these times of global economic recession, when developing countries are earning less for what they have to sell, often paying more for what they have to buy, and when funds for development assistance are scarcer, it would be foolish to imagine that in the next few years there will be any dramatic increase in the resources available for social development. This is why I have felt it vital, in partnership

with our many development allies, to seek out by every means available ways of improving the ratio between inputs and results, to try to do more for the world's children with essentially the same limited resources. And just as, in times of hardship, people suddenly discover reserves of energy and imagination they never knew they had, so they have done for children in these dark times.

In my introduction to the *Annual Report* last year, I discussed the signs that offered grounds for hope. UNICEF, in the 1982-83 report on *The State of the World's Children*, outlined a series of recent advances in both biological science and social organization which have the potential for protecting the health and lives of millions of children who would otherwise fall victim to the ravages of malnutrition, infection, and ignorance; and which would, in due course, help to slow down population growth.

We focussed attention in particular on accelerating the spread of four simple, low-cost techniques, which are integral elements of the primary health care and basic services activities which UNICEF has been promoting for some time. These are: growth monitoring of infants by regularly plotting their weight on simple charts, so that mothers can "see" the otherwise invisible onset of malnutrition; oral rehydration therapy, to treat the dehydration which results from diarrhoea, and which each year claims five million young lives; the promotion of breast-feeding as the safest, most nutritious infant food; and immunization to protect 10 million children a year from death or disability from six major communicable diseases.

We also highlighted three other programme priorities – food supplements, family spacing, and female education – which can contribute significantly to improving children's health and reducing child mortality. However, in comparison with the four techniques outlined above, food supplementation is more expensive, family



spacing is more difficult, and extending female education is both.

As I noted last year, none of these techniques is truly "new", although the technology by which some are applied has been recently enhanced, or our appreciation of their value – as in the case of breast-feeding – recently strengthened. What is new is the increase in social organization which makes it possible to reach people with them. This is exemplified by the expansion of primary health care services, the increase in literacy, the growth in the number of women's groups, and the phenomenal spread of communications media and transistor radios throughout the third world. Evolving social and administrative networks, reaching right into villages and squatter settlements, provide countries with the opportunity of spreading benefits to the poorest in their societies. It is the combination of the child health techniques with mobilizing existing resources and capacities which could save a high proportion of the children's lives now being lost – *if the world wants to do so.*

We are now seeing the signs that the world may, indeed, want to do so.

In December 1982, the Secretary-General of the United Nations appealed to "national leaders, to communicators, to health care workers and to concerned institutions and individuals" to "take imaginative steps to heal some of the most tragic wounds of underdevelopment and poverty". He cited the opportunities outlined in *The State of the World's Children* report, and invited the world to respond. Throughout 1983, the responses which we have heard in rhetoric and seen in action show that, even in times of hardship, the world has shown signs that it is willing to seize this opportunity for a revolutionary breakthrough in children's prospects for survival and good health.

This December, the Secretary-General was able to report: "Evidence accumulates that these and other such simple low-cost interventions are being extended both by governments and community action groups, with the co-operation of the media and other forms of mass communication. Government leaders from a wide range of developing as well as industrialized countries have pledged their support, reinforcing the United Nations' call for urgent and sustained action for children.

They have been joined by non-governmental groups such as the League of Red Cross Societies and authoritative professional bodies . . . parliamentarians in Asia, Africa, and the Americas, and religious leaders at world level as well as at national and community levels."

UNICEF's 1984 *State of the World's Children* report documents that evidence from around the world, and chronicles the commitments which have been made in the past year by leaders, organizations and institutions.

These signs are still scattered. Many of the pledges are yet to be turned into action. Many of the actions will be valiant attempts but will fall short. And, of course, more campaigns will need to be launched, and more programmes implemented, before a perceptible impact is made in the daily death toll of 40,000 small children. But what has happened is cause for excitement and hope.

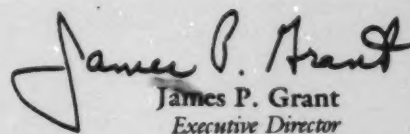
That sense of excitement and hope can be sensed within UNICEF. As well as increasing the effectiveness of our programmes and advocacy on behalf of children, we have also responded to the challenge of these difficult times within our own organizational framework. The ways in which we have done so – by refining our criteria for programming assistance, by relocating our personnel and technical resources, by increasing the cost-effectiveness of our operations – are documented in the main *Review* chapter of this 1984 *Annual Report*.

As I look back as this year of intense UNICEF endeavour draws to a close, I feel a profound sense of satisfaction. It stems not merely from the fact that the entire UNICEF family – Executive Board, secretariat, National Committees for UNICEF, donor countries and recipient countries alike – have responded so promisingly to the challenge for child survival. It stems from the growing signs that this opportunity – which we have called a "Child Survival Revolution" – has rapidly grown so much larger than UNICEF. It is becoming an integral part of the priorities of many multilateral and bilateral development assistance agencies; of the programmes of non-governmental organizations; of the coverage of information services and communications media; of the ministries of churches and religious or-

ganizations: and it is gradually taking its rightful place in the commitments governments make to their people, and in the demands people make of their governments.

The "Child Survival Revolution" is not a UNICEF programme. We can articulate its potential to those who will listen, and we can help translate ideas into action with the very limited resources which governments and concerned individuals entrust to our administration. But in the last analysis, we can only claim to be but one of the many forces which must join together to make this "revolution" real, and give children the chance which they would otherwise not have. Our greatest hope is that these forces will together constitute such a vast multitude that the UNICEF contingent in their midst will be indistinguishable.

This *Annual Report* reviews the work which UNICEF has been doing to help transform that revolution on behalf of children from a dream into a reality.


James P. Grant
Executive Director

UNICEF 1983-84: a review

Over the past few years, global economic recession has cast a dark shadow over the prospects for the poorest in the developing world. Modest recovery in the industrialized countries during 1983 was not mirrored in the developing countries, some of which are struggling hard to return to income levels of pre-recession years.

In the words of UN Secretary-General Javier Pérez de Cuéllar, these are times of "acute financial strain for social services and for international co-operation"—a situation which challenges UNICEF from several directions simultaneously. At a moment when women and children in poor communities face even more profound deprivation than usual, social sector expenditure is declining in almost every country; at the same time, there is considerable pressure on the shrinking resources available for international assistance, whose investment level in the social sector is parsimonious at the best of times. UNICEF itself has been hard-pressed to maintain, let alone expand, its own capacity to help women and children in need.

During 1983, a special study entitled *The Impact of World Recession on Children* was prepared by UNICEF staff and field offices, assisted by a panel of distinguished economists. The moment had come, in UNICEF's view, to assess as specifically as possible the actual impact of world economic recession on the well-being of children in different parts of the world.

The task of measuring changes in the well-being of children is difficult. It is easier in most countries to establish how many dishwashers have been sold in the past year than to find out how many children have been immunized against disease. In fact, one of the study's main recommendations was that a "Child Monitoring System" be set up in every country to provide early warning of deterioration in children's welfare.

In spite of data deficiencies, the evidence forthcoming confirmed in general the assumption on which UNICEF has been working in recent years, namely that children in poor societies are measurably suffering the recession's effects. In the northern

provinces of Zambia, for example, there are indications that children's height-for-age is falling; in Sao Paulo, the proportion of low-birth-weight babies is rising; in one area of Costa Rica, the number of children being treated for severe malnutrition doubled between 1981 and 1982.

The impact of recession, however, differs considerably in different parts of the world. In some countries, welfare programmes were less drastically cut than had been feared. In the Republic of Korea, allocations for mother and child health care actually increased and in Chile, food supplementation programmes for pregnant and lactating

mothers and the under-fives were expanded.

In general, however the consequences for children and mothers were grave. The situation in Sub-Saharan Africa is very serious. Economic growth in the region has lagged far behind that of other parts of the developing world. In many countries, per capita income was lower in 1980 than ten years earlier, and since then has dropped still farther. Disastrous terms of trade, drought and armed conflict have devastated many economies. In 1983, 22 African countries were on FAO's "Food Alert" list, giving rise to great concern about their



The situation in Sub-Saharan Africa is particularly serious. A mother and her two children, victims of drought, at a feeding centre in Nouakchott, Mauritania.

UNICEF 247/83/Murray-Lee

Within the poorest communities, it is often the most vulnerable — the women and children — who bear the brunt when times are hard.



UNICEF 340 83 Sprague

children's nutritional status.

It is clear that Sub-Saharan Africa needs to be singled out as a special case. Among basic services for children, education has been hard hit, and in others primary health care programmes are crippled by persistent shortages of supplies, including fuel for transport, spare parts for vehicles and refrigerators, medical equipment and essential drugs.

Among other findings, the study documents the multiplier effect which reinforces the impact of global economic cut-back on those least able to withstand it—on those so poor that they have little or nothing to fall back on when times are hard. The study estimated that a one per cent fall in the growth rate in the industrialized countries produced a one-and-a-half per cent fall in that of the developing countries. Within the developing countries, an echo of the same process passes the effect onto the poorer sections of society: a two per cent national decline, for example, can result in a 10 or 15 per cent decline in the incomes of the poorest communities.

Although there are signs in the industrialized countries of some economic upturn, in many developing countries the picture is of deteriorating well-being among children, with worse still to come. And by the same token, the level of resources available to meet

their needs both from within their societies, and from external assistance channels, is unlikely to grow over the rest of the 1980s.

During the past year, UNICEF has devoted much of its energy to developing a strategy specifically designed to meet this set of challenges. The first challenge is: how best to reverse the multiplier process, to respond to the mounting effect of economic hardship on those least able to stand the strain, with policies whose potential benefits—as opposed to disadvantages—are mutually reinforcing. In this context, as spelled out in the Executive Director's introduction to this *Annual Report*, UNICEF has redoubled its campaign to persuade opinion leaders and policy makers everywhere of the potential for a "revolution" in child survival and development prospects, in spite of the setbacks of recession.

Such a potential rests on the proven efficacy of the package of low-cost child health interventions first elaborated in the 1983 *State of the World's Children* report. The forceful promotion of these actions, through primary health care services using paramedical workers, reinforced by voluntary organizations, and backed up by media and educational campaigns, would constitute a great step forward. Until and unless countries assess the

impact of their existing policies on their children's well-being, and reconsider how to use the resources available in ways that ameliorate the recession's effects, the world's poorest women and children will continue to be its principal victims.

The second challenge is: where to apply UNICEF's own scarce resources to achieve the maximum impact for those in need. At the May 1983 session of the Executive Board, UNICEF decided to make an addition to the criteria used to allocate its financial and technical support between countries. A new emphasis is now being placed on the Infant Mortality Rate (IMR), as a guide both to the levels of UNICEF's assistance to countries and regions within countries, and to the focus and content of UNICEF's co-operation. The Executive Board decided that: "The IMR should be used in conjunction with other indicators (including notably GNP per capita and child population) and applied as a guiding principle, not as a rigid formula."

The third challenge is to UNICEF itself. Not only within UNICEF's programme of co-operation, and in its discussions with governmental and non-governmental partners, with sister organizations in the UN system and outside it, but within UNICEF's own structure and operations, the challenge of adjusting to the effects of the recession has had to be addressed.

The emphasis on IMR has led UNICEF to expand its level of co-operation and the allocation of its personnel and support services to countries with high IMRs, particularly those in Sub-Saharan Africa. Efforts have also been made to streamline the delivery of supply assistance to field programmes by the consolidation of most of UNICEF's procurement and supply operations in a new centre in Copenhagen. Special funds have been allocated for country or regional programmes specifically directed at reducing the IMR.

Within UNICEF's existing programmes of co-operation, a special effort has been made to reinforce the traditional areas of UNICEF's principal concern: the expansion of primary health care services, and their utilization for the four major thrusts which UNICEF has identified as having the potential for a revolution in child survival and development over the course of the coming decade. □

Child health and nutrition



The "child survival revolution" target: to lower infant mortality rates.

Co-operation in health and related nutrition activities continued to be UNICEF's largest field of activity in 1983. Resources were mobilized for an intensified campaign to reduce dramatically infant and child mortality and morbidity over the next five years.

Despite improvements in health care, the infant mortality rate (IMR) has remained extremely high in many countries, particularly in Africa, where drought-related food shortages exacerbated the deadly effects of malnutrition, combined with diarrhoeal, respiratory and other infectious diseases. The global economic recession led to shortages of drugs, vaccines, and transport in countries with severe foreign exchange problems. Even countries with well-developed services were forced to make some retrenchments.

Under these circumstances, the chief hope for what UNICEF has termed the "child survival revolution" lay in the extension of such measures as the monitoring of infant and child growth, oral rehydration for the treatment of diarrhoea, the promotion of breastfeeding, and universal childhood immunization, within the context of primary health care (PHC) services. The

energetic promotion of this "package" of child health and nutrition measures may in itself provide a boost to the extension of primary health service infrastructures.

The strategy for the child survival revolution was fully communicated to UNICEF's field offices. Many of them subsequently presented the strategy and argued its case in their country programme consultations with governments. At the same time there was a constant exchange of information with field offices on child survival and development issues. The wide support received from international and national leaders and developing among non-governmental organiza-

tions (NGOs) was also communicated throughout the UNICEF field office network. In many countries, NGOs have long been close partners in UNICEF country co-operation, and in these countries UNICEF sought their active support in accelerated programmes to reduce infant and child mortality and morbidity.

UNICEF's natural allies on the international front included WHO, the leading specialized international organization, as well as the International Fund for Agricultural Development (IFAD), FAO, UNDP, WFP, the World Bank, and many of the principal bilateral aid agencies.

Primary health care

Diarrhoea, acute respiratory infections, and malnutrition were, as always, the major contributory causes of death in children during 1983. Many countries also reported a resurgence of malaria in areas where it used

to be controlled. High perinatal mortality and high maternal mortality were cited as special problems in some countries. UNICEF's continued emphasis on primary health care recognized that these and other health problems can



The PHC approach relies on communities to take part in running preventive and simple curative services, through nominating members for training, and contributing for medicines and advice. A "clinic" in Chad.

ICEF 9093/Murray-Lee

In Colombia's mountainous Cauca Department in the southwest, a special campaign has been launched to focus on four life-saving aspects of primary health care for the young child: growth monitoring, oral rehydration therapy, breast-feeding, and immunization.

In its present pilot stage, the project is being carried out in two adjacent districts, Piendamó and Morales. While far from being the poorest in Cauca, these have been selected because they have a fairly good primary health care infrastructure, so as to give the project a fair trial. For the past eight years, 21 health *promotoras* have been visiting the families in their neighbourhoods, introducing them to sound health and hygiene practices. Now these *promotoras* have been given special training in growth monitoring and the other project components.

Even if these are not the worst-off areas of the Cauca, stark poverty is common enough to complicate implementation of what would seem to be straightforward child health measures. The introduction of the growth chart, for example, has been fraught with special difficulties.

Why it is important to fill in the chart, and how it will help the child, is not easily understood by mothers whose first concern is satisfying their children's hunger. In the previous growth monitoring programme, they were given food rations.

They have also been told that the child's first weighing must take place at one of the area's four health centres. Some mothers, especially those with many small children, simply cannot make the long trek. Others say, "What good is it to weigh my child if I have nothing for him to eat?"

Dr. Angel Erazo, the resident doctor at Piendamó health centre, recalls one woman who tore up her child's growth chart in his



UNICEF 232/83/Breiter

face. "What could I say? She had a boy who was dying of under-nourishment. We can't practise preventive medicine here until we have real solutions for our problems," Dr. Erazo says.

In spite of this and other difficulties, the project has succeeded in getting off the ground "in parts", according to Nurse Amparo, one of the staff at the Piendamó health centre, who helps supervise the *promotoras*. The new baby scales have an unfortunate tendency to slip and land their squealing burdens on the ground, and modifications in the design had to be urgently requested. But the rest of the equipment—growth charts, oral rehydration salts, and thermos flask vaccine carriers—have all arrived and been put to good effect.

The oral rehydration salts have been generally well received and acceptance is high. As Nurse Amparo notes, "They don't prevent diarrhoea. Diarrhoea is prevented by potable drinking

water, latrines, hygienic living conditions—things we have to work at over the long term. But they are preventing many deaths, and that is important."

Breast-feeding is almost universal in this region, and in itself is no problem. Emphasis is therefore being placed on its duration, to convince mothers to continue breast-feeding beyond four or five months, with, of course, the proper supplementary foods. "We explain why it is better to nurse for at least a year. We talk about the baby's health and child spacing," says Nurse Butica. "But for some mothers it is hard. They may have to go to the fields to work, and for economic reasons will find it difficult to nurse as long as they should."

The Cauca programme has been at its most innovative in the immunization strategy. This is based on "mini-concentrations" of people in rural areas. Each of the *promotoras* first takes a survey of all the children in her coverage area who need to be immunized. Community leaders are then asked to let the people know when the immunizations will be given, and where. The sessions are usually held at a local school or home, and community leaders come and help out.

Among the more encouraging aspects of the whole primary health care programme is the formation of local health committees. One of the most outstanding is that in the small town of Carpintero, whose president is Jorge Alzate, the police inspector. Even though all the members of the committee are men, they are not inhibited about giving spirited lectures on breast-feeding and family planning. As Maria Cecilia López, the director of the project puts it, this is a definite step forward. "When men begin to talk about health problems that only women discussed in the past, it is a sign of deep transformation in a community's attitudes".

only be tackled by providing better services at the community level.

In general, there was progress and expansion in primary health care services in 1983, with an increased acceptance of the PHC approach, and greater understanding at the national level. UNICEF played an important advocacy role in several countries and supported national seminars on PHC and national reviews of PHC strategy. In Colombia, Nepal, Oman, Philippines, Sudan, Swaziland and Thailand, reviews and workshops focussed on the retraining of community health workers, specifically to emphasize child health measures.

Community involvement is perceived as being at the heart of the PHC approach, but the health establishment is often reluctant to accede to community participation in PHC management. This problem is being dealt with in the Philippines by including organization and communication skills in the training of government health workers.

In some countries it has been difficult to obtain support for local community health workers. Kenya and Malawi are training district teams to mobilize community leaders for planning and managing PHC. Swaziland has set up community health councils and carried out leadership courses for their members.

Economic constraints have encouraged more countries to promote community financing. In Thailand, weaning food co-operatives, run by women's organizations, have been successful. Village pharmacies are being developed in Cameroon. Ethiopia is using revolving funds for the purchase of drugs.

With the recognition that behavioural change is a fundamental prerequisite for achieving health goals, health education is receiving more emphasis. There was major stress put on communication programmes for health in 1983 in the Arab Gulf countries, Central America, Liberia, Mauritius, Syria and Tanzania.

In many countries the maternal and child health (MCH) content of PHC is relatively weak, and UNICEF advocacy for child survival has underlined the need to strengthen MCH activities. This has taken the form of expanding and strengthening the training of traditional birth attendants (TBAs), who still carry out the majority of deliveries in many countries. In Sudan, a new programme has started to



UNICEF 242 83 Black

train traditional birth attendants, since trained village midwives only cover a limited part of the population. Nepal, Pakistan, Malawi, Djibouti, Papua New Guinea, and North Yemen are also expanding their TRA training; and in many countries TBAs are being trained in the use of oral rehydration therapy for diarrhoea.

Most of UNICEF's financial support to PHC has gone into training and equipment. A critical area that UNICEF, in co-operation with WHO, has been addressing in recent years is the supply of essential drugs. Nothing undermines the credibility of health services more than shortages of drugs to treat common diseases such as pneumonia, malaria, and parasitic infestations. Foreign exchange shortages in many countries have exacerbated the problem. In Tanzania, for example, a study comparing health services in 1978 and 1983 showed an increase in staffing, training, and construction of health centres, but a reduction of almost 50 per cent in items requiring foreign exchange, including drugs.

UNICEF has been a partner with WHO in a joint action programme on essential drugs for several years. UNICEF has supplied drugs to the value of about US\$15 million a year through regular country programmes, and has also helped countries to identify their requirements of essential drugs, and to train health workers in their proper use. In 1983 UNICEF increased the level of its co-operation in this joint programme, giving special attention to a number of African countries, including Ethiopia, Somalia, Tanzania, Guinea Bissau, Upper Volta and Mozambique. Tanzania launched a five-year programme to ensure a better supply of essential drugs, with US\$30 million in support from DANIDA.

UNICEF normally provides health centres with only an initial supply of essential drugs. In Thailand, as part of the PHC programme, a network of nearly 10,000 village drug banks has been established to ensure the replenishment of the health services' pharmaceutical supplies. □

*Zimbabwe: a child health card in widespread use for monitoring growth.
Liberia: an illustrated booklet on ORT.
Jamaica: a leaflet to promote breast-feeding.
Nigeria: a poster exhorts mothers to have their children immunized.*

Towards a revolution in child survival

Within the context of the expansion of primary health care services, four specific interventions have been singled out by UNICEF as having the potential, in combination with each other, for bringing about a dramatic drop in infant morbidity and mortality. It is this "package" of low-cost interventions that UNICEF has termed the key ingredients of a "child survival revolution", and which are to be given a special emphasis within ongoing primary health care programmes.

Monitoring children's growth

The systematic use of simple charts to show mothers whether or not their children are growing and gaining weight correctly can be an effective aid to better child health and nutrition. Unless a child is seriously underweight, or has the tell-tale signs of advanced protein-calorie malnutrition (listlessness, discoloured hair and a distended stomach), a condition of under-nutrition may not be visible to a mother. A health card, which charts the child's monthly progress up the "road to health", can help the mother to "see" her child's nutritional status. UNICEF is supporting the use of growth charts as an aid to better nutrition, and the training of health workers and mothers in how to use the charts to monitor children's growth and record other health data (see profile inset from Zimbabwe).

In some countries charts are being widely used in mother and child health clinics, and in others educational drives are being conducted to promote their use. There are, however, a number of problems. Community-based growth monitoring requires properly calibrated baby scales, which may not be available. Some health service professionals are reluctant to let the mothers keep the charts between weighing sessions, because they are viewed more as clinical records than educational tools. Confusion has arisen in some countries because different types of cards are introduced by different organizations.



The majority of deliveries are still carried out in many countries by traditional birth attendants. A new baby comes into the world, in Egypt.

ICEF 8246/Wolff

Evaluations of the use of charts by village health workers, and of mothers' understanding of their purpose, have shown mixed results. In Indonesia, 95 per cent of volunteers were found to use the chart properly, and the mothers understood it. Studies in Sudan, on the other hand, showed that neither community health workers nor mothers were convinced of its value.

There is a need for more in-service training of health staff and community volunteers in the growth chart's use. In Zimbabwe, 55 district seminars for health staff are to be held in 1984, and special training of health staff and community health workers in growth surveillance is also being carried out in Nicaragua, Belize, and Niger. In Indonesia and Liberia, traditional birth attendants are being trained in the use of the growth charts.

An important function of growth charts is to alert mothers to signs of mal- or under-nutrition they have overlooked, so that they can make a special effort to provide the child with more food. In cases where sheer poverty makes it impossible to do this, other solutions will have to be found: subsidized food for the poorest families, for example.



CHILD HEALTH: In 1983 UNICEF

- » co-operated in child health programmes in 102 countries: 43 in Africa, 21 in the Americas, 27 in Asia and 11 in the Middle East and North Africa region
- » provided grants for training, orientation and refresher courses for 68,900 health workers: doctors, nurses, public health workers, medical assistants, midwives and traditional birth attendants
- » provided technical supplies and equipment for 53,700 health centres of various kinds – especially rural health centres and subcentres
- » supplied medicines and vaccines against tuberculosis, diphtheria, tetanus, typhoid, measles, polio and other diseases

***"Forward with the prevention of diseases!"* — ZIMBABWE**

In the grounds behind Chinyika Clinic in Mashonaland, Zimbabwe, a group of mothers is seated beneath a tree, their small children in their laps and older ones gathered around them. A mobile immunization team is holding a clinic.

"Pamberi nekudzivirira zvirwere!" shouts Sister Nhliziyo, the sister in charge of community health: "Forward with the prevention of diseases!"

The mothers respond: *"Pamberi!"* - "Forward!"

Sister Nhliziyo holds up a child health card. "What is this?" she asks.

"It is for preventing diseases," says one mother.

"How does it prevent diseases?"

"The card shows the diseases your child is supposed to be vaccinated against," answers another mother, and another - with prompting - manages to recite the names for all six immunizable diseases.

A mother puts up her hand. "The card also shows if your child is growing well. When you bring your child, the nurse puts him on a scale and tells you if you are feeding him properly."

This kind of question and answer session is bringing home to Zimbabwean mothers the need to be on the look-out for their children's growth, and how to use the health card as a child-care aid.

Most health cards in Zimbabwe up to now have been supplied by a major baby food company. A larger, more attractive card with a picture of a mother breast-feeding her child has now been issued by the Ministry of Health. This card is to be the standard one used: mothers can take their children to a clinic anywhere in the country and the same information will be recorded. Half a million of the new cards have been printed with UNICEF financial assistance.

On the card, a single line shows the child growth curve, the normal weight at a given age. The previous cards had a "green road to health" which the mothers found hard to

understand. The new cards carry a lot of additional information as well: a record of the child's illnesses; when solid foods were introduced; if there are more than five children in the family; and the name of the health worker who initially explained the uses of the card to the mother.

To help ensure widest use of the health cards, hospitals and clinics ask every mother who brings a sick child for treatment for the child's health card. Mothers who have forgotten the cards go to the end of the line. This may seem severe, but the Ministry of Health attaches great importance to health cards as an aid in promoting child nutrition, and in reaching the country's target of universal child immunization by 1990.

Mothers are coming to see a symbolic link between the cards and their children's health. But the card only works if all levels of staff dealing with mothers and children understand just how the cards can help. For this reason, introduction of the new cards has been accompanied by an intensive training programme for all levels of health workers.

Where effectively used, growth charts can serve as a useful entry point to primary health care in the community, motivating mothers to participate in community-based health and nutrition activity. Many growth charts contain information about a child's immunization record, and other key health data. In many countries the charts have proved valuable in the context of immunization programmes.

Oral rehydration

Within the context of primary health care, UNICEF has undertaken a major effort to promote the use of oral rehydration therapy for the treatment of diarrhoeal diseases. These represent the largest single cause of sickness and death in young children.

An estimated five million children under five years of age die every year in the developing world as a result of diarrhoeal diseases, and an estimated 60-70 per cent of diarrhoeal deaths are caused by dehydration. Oral rehydration therapy (ORT) can correct dehydration and prevent most diarrhoea-associated deaths.



UNICEF 353/83 Zimbabwe

A child with acute diarrhoea begins to lose essential water and salts from the onset of illness. The major breakthrough associated with ORT is the discovery that a solution in water containing glucose as well as common table salt can be absorbed through the wall of the intestine even during acute diarrhoea. This method of replacing the lost fluid and salts greatly simplifies the treatment of dehydration associated with diarrhoea.

While oral rehydration therapy has revolutionized the treatment of seriously dehydrated cases, the spread of diarrhoeal infection also needs to be curtailed by preventive action. Many children suffer repeated bouts of diarrhoea due to poor environmental sanitation. Measures to improve water supply and sanitation and to educate mothers in the importance of personal cleanliness are therefore essential to the control of diarrhoeal disease: (see *Water and sanitation*, page 19).

Progress in oral rehydration therapy (ORT) was made on many fronts in 1983: advocacy, provision of oral rehydration salts (ORS); national production of ORS; dissemination of information about home-prepared ORS mixtures; and technical advances in the formulation and packaging of ORS.

In June 1983, WHO, UNICEF and USAID co-sponsored an International Conference on ORT in Washington, where WHO and UNICEF published a "Joint Statement on the Management and the use of Oral Rehydration Therapy". In November, some 4,000 delegates to the International Congress of Pediatrics in Manila heard authoritative endorsements of WHO/UNICEF policies on the promotion of ORT. UNICEF also supported the training of health care professionals and community level health workers in the use of ORT in many countries.

Material and technical help was given to 21 countries to produce their own ORS, either on an industrial scale or through small-scale manufacture. More than 30 countries now meet most of their needs, producing upwards of 100 million packets of ORS a year. Thailand, Philippines and Indonesia are among those moving towards self-sufficiency. UNICEF also provided in 1983 over 29 million packets of ORS to approximately 80 countries. Concerned bilateral agencies, including the Swedish International Devel-



ICEF 9261/Thomas

The use of home-prepared oral rehydration solution is being strongly encouraged. In Pakistan, a father gives his child a home-prepared mixture to treat diarrhoea.

opment Agency (SIDA) and USAID, also supplied large quantities.

A packet of ORS includes prescribed amounts of salt, potassium chloride, sodium bicarbonate, and glucose, for solution in one litre of water. Due to the instability of the bicarbonate, relatively expensive aluminium packaging is required. Research now indicates that citrate may be used in place of bicarbonate, enabling the mixture to be packaged more cheaply. Commonly available starches, such as rice starch, are also being tried out. For home use, some countries are packaging ORS in amounts suitable for local measuring units in place of a litre: in Thailand, for example, the dosage is designed to be mixed in a *Mekong* whiskey bottle, which contains 75 centilitres.

The use of home-prepared oral rehy-

dration solutions is being strongly encouraged. Continued and augmented feeding, especially the continuation of breast-feeding, is recognized as being of the utmost importance in combatting the cycle of malnutrition and diarrhoea. Health education to counter the common belief that food and liquid should be withheld from a child suffering from diarrhoea is of vital importance. Like all aspects of primary health care, the ORT programme is firmly based on community involvement and participation.

The promotion of breast-feeding

Studies published in 1983 confirmed that breast-feeding still predominates in the rural areas of almost all developing countries, but that in the growing metropolitan areas bottle-feeding is on the rise. Estimated global sales of infant formulas rose from US\$1.5 billion in 1978 to US\$4 billion in 1983. In the light of this trend, anxiety about changing maternal feeding patterns can not be restricted to urban areas. Most of the increase in formula sales occurred in the more rapidly industrializing developing countries. The aim of UNICEF and WHO co-operation with countries in the promotion of breast-feeding is to protect and reinforce the practice of breast-feeding in rural areas, and to help urban mothers resist the trend towards bottle-feeding.

Continued efforts to strengthen the application in individual countries of the International Code of Marketing of Breast-milk Substitutes, adopted by the World Health Assembly in 1981, is one element of the overall campaign in support of breast-feeding.

A considerable number of new studies published in 1983 reinforced the arguments against bottle-feeding. In rural Jamaica, for example, it was found that diarrhoea incidence increased directly with the degree of bottle-feeding, and was three times as high among exclusively bottle-fed compared with exclusively breast-fed infants. In Congo, a UNICEF-sponsored study (see profile, inset) echoed the evidence accumulating from all over the world that infant malnutrition is frequently co-related with a reduced period of breast-feeding, and warned that the social changes that bring this about are far more complex than is sometimes implied by the "breast versus bottle" protagonists.

The use of the media to promote breast-feeding was reported from many countries. In Brazil a UNICEF-assisted multi-media National Breast-feeding Programme won the "Top de Marketing" award, the country's "Oscar" in marketing. There was widespread distribution of breast-feeding booklets and posters in Egypt and Saudi Arabia, and in the Philippines, the Nursing Mothers Association published, with UNICEF assistance: "Breast-feeding—A guide for

Breast and bottle

CONGO

In Congo, practically all infants are breast-fed after birth, and most continue to be given some breast-milk until 14 months of age. But few infants are exclusively breast-fed for the recommended period (birth to between four and six months), and the use of commercial formulas and other supplements during the earliest months of life appears to be increasing, with serious health implications. These findings are reported in a study on current breast-feeding behaviour commissioned by UNICEF*.

The advertising, promotion, and sale of imported infant foods is widespread in the country. But certain social changes - commonly regarded as signs of progress - are also contributing to a reduction in breast-feeding. These include the decline of polygamy, increased enrolment of girls in secondary school, and a rise in hospital births.

Formerly, exclusive breast-feeding was discontinued only when teething began (about six months), or when the infant was able to sit. At this stage, small portions of the family food would be gradually added to the baby's diet. Breast-feeding continued for at least two years, during which the mother was subject to a strict taboo against sexual intercourse. With the increase in monogamous marriages, husbands have no other wives to turn to, and the sex taboo has therefore been modified. This has shortened the total duration of breast-feeding.

The trend towards a shorter period of *exclusive* breast-feeding correlates with the increase in school enrolment, according to the report. Most young women conceive their first child at 14 or 15 years, though formal marriage, which depends on the final payment of the bride-price, usually takes place later. Mothers still in secondary school have the highest percentage of bottle-fed infants.

Another change affecting breast-feeding behaviour appears to be the enforcement of compulsory hospital childbirth. The stress of unfamiliar surroundings may inhibit the mother's milk-producing reflex. When this happens, many hospital staff routinely prescribe formula feeding.

Infant-feeding practices are also affected by the attitudes of the mothers themselves towards breast-milk, which - they believe - can be contaminated: diarrhoea is almost always attributed to this cause. Consequently, the breast is usually withheld from a child with diarrhoea or vomiting.

Mothers' lack of appreciation of breast-milk's properties are reinforced by the advice they receive from nutrition educators, who advise mothers to start supplementary feeding very early, at two to three months, or less. Meanwhile, formula promotion misleads mothers into believing that early supplementary feeding is necessary.

The upshot, according to the report, is that 45 per cent of two-months-old infants are receiving other foods than breast-milk, and at three months the figure is 78 per cent. For one child in two, the first supplementary food is an imported commercial product. A local infant food, *bouillie de maïs* (maize porridge), is sold in local markets and often used by poorer mothers. In either case, diarrhoea due to the unsuitability of the food or its unhygienic preparation is common.

Studies such as this Congo example, which analyze changes in breast-feeding behaviour, are an important prelude to any campaign to promote or reinforce breast-feeding as one of the keys to a healthy start in life.

* *Infant Feeding Practices in the Peoples Republic of Congo* - A.H.F. Slothouber

Training nurses and health workers how to encourage breast-feeding is a key child survival activity. A seminar in a hospital in Bangladesh.



UNICEF 076 83 Supachai

nurturing your baby".

UNICEF provided financial support to the International Organization of Consumers Unions (IOCU) to conduct regional and national workshops in South-east Asia, East Africa, the Caribbean, Latin America and South-central Asia on the protection and promotion of breast-feeding for leading NGOs. The IOCU also produced prototype radio scripts that were supplied to 43 Asian broadcasting networks as a World Food Day project.

The attitudes, knowledge and practice of the medical profession are a major factor in the promotion of breast-feeding, and efforts were made in 1983 to include thorough orientation on breast-feeding in all UNICEF-supported training programmes. Unfortunately, the normal routines in many hospitals still discourage, or at least inhibit, breast-feeding. Practices which support breast-feeding include giving the infant to the mother to start breast-feeding immediately after delivery; and "rooming-in": keeping the new-born baby with the mother instead of in a special nursery. Rooming-in is now growing as a hospital practice in the Philippines, Indonesia, and many Caribbean and Latin American countries. Kenya held a national workshop on infant feeding practices, and subsequently endorsed these practices to all medical officers and hospitals.

The promotion of breast-feeding in

urban areas cannot succeed in the absence of measures to support urban mothers, many of whom are wage-earners and have to provide for their families. Preliminary results of a survey in Mauritius, a small island country that is almost entirely urban or suburban, indicated that few Mauritian women breast-fed for more than three months. Another survey in Burma revealed that 34 per cent of poor urban working mothers of infants under three-months-old were bottle-feeding.

There was progress in 1983 in the adoption of the International Code of Marketing Breast-milk Substitutes, but implementation tended not to be sufficiently forceful. More than 20 countries have now adopted the Code, and close to 100 more are engaged in actions related to the Code. But most national regulations are weak in a legal sense, and there is little monitoring of violations. Yet many of the most damaging practices of infant formula manufacturers—extensive media advertising, distribution of free samples in hospitals, and the use of saleswomen dressed as "milk nurses"—are certainly decreasing. In Papua New Guinea, for example, it was reported: "Baby bottles have disappeared from pharmacies and stores. One no longer sees women in the streets of urban Port Moresby or in rural villages feeding babies from unsanitary bottles."

Immunization

UNICEF has joined WHO in accelerated support to the expanded programme of immunization (EPI) to immunize all children against diphtheria, pertussis (whooping cough), tetanus, measles, poliomyelitis and tuberculosis. Immunization against tetanus for women of childbearing age is also included.

UNICEF provides direct support to EPI in 80 countries, and is also providing indirect aid to EPI in Latin America through a US\$500,000 contribution to a regional revolving fund for vaccine procurement. UNICEF remains the main international provider of vaccines, buying each year more than US\$4 million worth, and has helped countries produce their own supplies.

In 1983, despite significant progress, the goal of universal childhood immunization remained distant. Immunization programmes have been underway for some years in many developing countries, but their achievements are too often marred by low coverage. This results from a combination of lack of logistical organization; difficulties in maintaining the "cold chain", such as lack of a steady power supply to ensure vaccine potency; and lack of understanding among mothers and community leaders of the preventive health value of childhood vaccination.

DPT (diphtheria, pertussis, tetanus) and polio immunization require a series of three shots each for full protection. A mother unconvinced of their importance is not motivated to return with her child for the second and third shots, particularly when this involves a long trek on foot to a health centre many miles away.

During 1982/83, national EPI reviews were underway in many countries. The reports indicated that, in Africa, where coverage is lowest, only 19 per cent of children under 12 months of age have been immunized with all three DPT shots, while 31 per cent have been vaccinated against tuberculosis. In South-east Asia, where reports on the extent of immunization are much more complete, only 10 per cent of children surveyed have received a third polio shot. In the Middle East, 28 per cent of the children have received a third polio shot and 24 per cent a third DPT, figures which compare favourably with the 22 per cent

They thought one shot was surely enough — PHILIPPINES

In 1976, the Philippine Ministry of Health, with assistance from UNICEF and WHO, launched a programme to immunize all young children against six communicable diseases for which low-cost and effective vaccines are available: diphtheria, pertussis and tetanus (DPT shots); tuberculosis (BCG vaccine), poliomyelitis, and measles. By 1983, immunization of eligible children had reached 60 per cent for DPT, 56 per cent for polio, and 78 per cent for BCG. The measles campaign was launched last, in 1982, with UNICEF providing the vaccine, and reached 48 per cent coverage in 1983.

This has been a most encouraging start to the programme, given that it meant overcoming enormous organizational problems in a country of 50 million people living on 11 major islands and hundreds of smaller ones. But before the campaign could develop such momentum, serious human relations problems also had to be surmounted. Many mothers who brought their babies for the first DPT shots failed to return for the second ones. And when mothers asked when the shots were due, most health workers responded merely, "They are medicines. Good for your baby." Traditional *barrio* (neighbourhood or village) leaders were unimpressed by the programme — they had no shots when they were young, yet they were still alive and healthy.

To address these problems of misunderstanding and lack of motivation, a series of five-day communications workshops was introduced as a part of the health workers' training for the expanded programme of immunization (EPI). The six immunizable diseases were fully explained so that health workers could transmit this information to mothers, and a major emphasis was placed on how to communicate the information effectively and stimulate the interest and involvement of the community.

One of the places where this new emphasis on better human relations has paid off is San Pablo, a municipality of 153,000 people where in 1980 only 21 per cent of mothers and children had been immunized. Today, only a handful have not been reached. According to San Pablo's city health nurse, a series of communication workshops held for local midwives and other immunization workers turned the tide. During each workshop, the nurses and midwives went out into the remotest neighbourhoods of San Pablo, talking to community leaders, convincing them of the importance of bringing the children for immunization. "I guess it's easy now," says the head nurse. "We've already established good contacts with the village captains. They know that the programme is for their children. And

the city mayor's information officer helps by announcing our schedule for giving vaccines on his radio show."

Today in San Pablo, the 17 midwives assigned to the immunization programme have worked out an efficient strategy. They post the date of their neighbourhood visit on the health unit's bulletin board and make sure it is announced on the radio too. Three days before the visit, a midwife reminds the *Barrio* captain, who then helps round up the mothers and children, sometimes with the help of the local mothers' group. The immunization team is careful to explain to the mothers just what immunizations are being given and why "one shot is not enough". Today, San Pablo's coverage of immunization among young children exceeds 95 per cent.



UNICEF 242/83/Sc28

In Bali, Indonesia, the traditional *dukun*—midwife—is still the key helper at most childbirths. This role is normally the exclusive preserve of women, but in Bali almost all *dukuns* are men.

Hinduism as practised by the Balinese contains no taboo against a man touching intimate parts of a woman's body, as long as the aim is to aid or heal, and neither *dukuns* nor mothers express any awkwardness about what, in many other traditional societies, would be quite unthinkable. *Dukuns*, they say, need mystical powers to counter evil spirits which, it is believed, are likely to strike at the moment of birth. To acquire these powers, they must practise meditation in a graveyard after midnight, and undertake other rigorous forms of preparation not regarded as suitable for women.

One of the oldest and most famous of Bali's *dukuns* is Jadeng, who claims to be 85-years-old. Over the years, patients have come from every part of Bali for consultations. Jadeng began life as a *balean*, or medicine man, and turned to delivering babies in the 1960s at the suggestion of a doctor in the local hospital. Instead of the familiar traditional birth attendant kit, Jadeng sports a little black bag, like a doctor. Jadeng is unusual in that he considers his primary occupation to be that of *dukun*. Most are not professionals: midwifery—or midhusbandry—is a service they perform for the community, with no payment except in kind. They are mainly farmers or land labourers, and some are quite poor, earning as little as Rp 200 (about US20 cents) a day.

Increasing contact with the rest of the world is introducing change in Bali. Many women are beginning to prefer delivery by professionally trained midwives—*bidans*—in the health centres. The *dukuns*' numbers are slowly diminishing; those remaining are generally old, and few young ones are joining the ranks. However,



UNICEF 235/83/Suryakusuma

the *dukuns* provide tremendous psychological and spiritual support to many women in labour, and as trusted members of the community and a revered "institution", they are in an ideal position to promote new health messages.

The Bali health authorities have therefore, with UNICEF assistance, taken steps to enhance the *dukuns*' capabilities, giving them new, scientific knowledge about how to ensure safe delivery. They are also taught to recognize complications and refer them to a health centre, so the training helps establish a formal link between the *dukuns* and the official health services.

The *dukuns* are also taught to encourage mothers to carry out simple health precautions. They distribute vitamin A and iron

tablets, and show mothers how to use oral rehydration salts. And they are required to give monthly reports on the number of births they attended, the sex of each baby, the weight, and whether the baby lived or died.

In introducing new health procedures, health officials take care not to denigrate older practices which do no harm, or to interfere with the spiritual functions. But there have been questions about the *dukuns*' ability to carry out the extended functions in which they are being trained, and these have not been answered to everyone's satisfaction. Most of the *dukuns* are simple people, and many are illiterate. But while *dukuns* like Jadeng still have great authority in the community, their role in the care of Balinese mothers and their newborn cannot be ignored.

for both BCG and measles (one shot each).

The expanded programme of immunization has made remarkable progress in China, Thailand, and Philippines. Other countries with relatively high coverage include Egypt, Jordan, Lesotho and the Seychelles. In many other countries, especially in Africa, EPI is still largely restricted to urban areas.

UNICEF, with WHO, has helped organize many national training programmes in EPI management and logistics. Mass media channels are being used to inform mothers of the importance of vaccination, and special attention is being given to the training of community health workers and TBAs.

Where EPI has been initially carried out as a special service, it is now being integrated where possible into the

maternal and child health (MCH) and primary health care services, with the participation of health care workers and community leaders. This has been successfully accomplished in Indonesia, Thailand and the Yemen Arab Republic, but not in other countries, including Nepal, where the district health services were not yet managerially and logistically able to absorb the EPI programme.

It is clear that to reach the vast number of young children needing immunization and to maintain the thrust of EPI for succeeding generations, it must be possible for vaccinations to be provided eventually through the permanent primary health care infrastructure. The task of educating community leaders and gaining their lasting support in reaching mothers is vital in reaching a high level of immunization coverage. □

Child nutrition

The attack on hunger and malnutrition among children is inseparable from the spread of mother and child health (MCH) and primary health care (PHC) services. All the special measures which UNICEF is emphasizing for children's survival and development have a direct bearing on their nutritional status.

The mutually reinforcing relationship between disease and malnutrition is the greatest threat to a young child's health: both respiratory and diarrhoeal infections flourish where a child is already under-nourished. Weight loss can also be triggered by an immunizable disease such as measles, causing an abrupt and sometimes fatal dip in the child's growth curve. Meanwhile, breast-feeding provides optimal nutrition during the early months of life; and the purpose of promoting growth charts is to encourage mothers to monitor at home their children's dietary intake and growth.

However, in addition to the four specific components of the child survival revolution, other measures specifically related to the ability of mothers to provide a healthy diet for their children continued during 1983 to be an important emphasis in UNICEF's co-operation.

These included supplementary feeding programmes in areas where drought or civil disturbance had caused crop failure. A high priority was also given to the control of dietary deficiency diseases, such as anaemia, goitre, and night-blindness, by the distribution of iron/folate tablets, iodized salt, vitamin A, and other food supplements. Distribution of these was carried out with UNICEF assistance in many countries, including Lebanon, Angola, Indonesia, Zimbabwe, Egypt, and Haiti.

The introduction of appropriate weaning foods at the correct age is vital to the health and sound nutritional status of the young child. UNICEF has long been active in this field, which dovetails with the increased emphasis on the protection of breast-feeding. Among low-income families, proper weaning is often more difficult to promote than breast-feeding, which is cost-free. Some mothers, in fact, continue breast-feeding exclusively for far too long because they are not aware of



The expanded programme of immunization, spearheaded by WHO and UNICEF, is giving special training to community health workers so that they can give vaccinations. A Colombian child is a reluctant beneficiary.

UNICEF 132/83/Mera



CHILD NUTRITION: In 1983 UNICEF

- » co-operated in nutrition programmes in 93 countries: 39 in Africa, 20 in the Americas, 25 in Asia, and 9 in the Middle East and North Africa region
- » helped to expand applied nutrition programmes in 19,600 villages, equipping nutrition centres and demonstration areas, community and school cichards and gardens, fish and poultry hatcheries
- » provided stipends to train 20,400 village-level nutrition workers
- » delivered some 24,438 metric tons of donated foods (including wheat flour, non-fat dry milk, special weaning foods and nutrition supplements) for distribution through nutrition and emergency feeding programmes

the child's need for additional foods after four to six months of age. They do not know how to prepare balanced supplementary foods in a hygienic manner, and sometimes cannot afford to feed their children adequately. Many mothers in the expanding city slums are the sole earners for their families, and they have little time to prepare the right kind of food. Meanwhile, commercial alternatives are expensive.

In many countries, measures are being taken to address this issue. In rural areas, the emphasis is on home and community production of weaning foods, with recipes based on locally available ingredients. Such activities, normally including a large motivation and education component, are currently being supported by UNICEF in Indonesia, Iraq, Ethiopia, Tanzania, and Brazil. In Thailand, villagers are being taught to identify malnourished children in the weaning and post-weaning age group, and to run the

grammes through women's and youth organizations.

UNICEF is also supporting the industrial production of low-cost supplementary weaning foods, mostly for use in urban areas, in Algeria, China, and Laos. During 1983, the establishment of fruit and vegetable gardens in household and school compounds, and the preservation and storage of home-grown foodstuffs, were supported in many countries, including Jamaica, Uganda, Guatemala, Mexico and South Korea.

A leading cause of infant deaths in the developing world is low birth weight. Low birth weight babies account for 10 to 15 per cent of births and between 30 and 40 per cent of infant deaths. The chief factor appears to be maternal malnutrition. A study in India has shown that birthweights can be raised to normal levels by a modest daily supplement of calories and protein for women in their last three months of pregnancy. In primary health care programmes, the importance of better maternal nutrition is being increasingly emphasized.



UNICEF 043 83 Sprague

A major WHO/ UNICEF nutrition programme

A five-year Joint WHO/UNICEF Nutrition Support Programme (JNSP) proceeded in 1983. Approved by the UNICEF Executive Board in 1982, the US\$85.3 million programme is being entirely funded by the Italian Government. The programme represents a commitment by WHO and UNICEF to provide special co-operation in certain countries where the problem of child malnutrition is particularly acute. Around 18 countries committed to primary health care will eventually be involved.

By the end of 1983 concrete project outlines, with an emphasis on convergent activities, had been drawn up for implementation in 14 countries. In the Ségou region of Mali, for example, the main components will be immunization, community participation in strengthening the PHC network, child growth monitoring, home-made weaning foods, nutrition education, family health education, oral rehydration, and child care. In Sudan's Red Sea Province, activities in both rural and urban areas will include the involvement of primary schools in nutrition, education and child development. In Tanzania's Iringa region, preparations included feasibility studies on rural sanitation, food storage, small scale food processing and preservation, and low cost technology to reduce the workload of mothers.

In three Andean countries, Bolivia, Ecuador, and Peru, a JNSP project aims at reducing the prevalence of iodine deficiency disorders including goitre and cretinism. The incidence of goitre in these countries now ranges from 20 to 60 per cent in different areas. In Burma, project plans provide for improving nutrition for pregnant women and children under three-years-old in all villages with a resident midwife or auxiliary midwife. In Nepal, the project plans include credit for

At a nutrition centre in Kerala, India, children stand on the scale to see whether they are growing and gaining weight.

women's economic activities and small scale food production through a link with the Small Farmers' Credit Scheme of the International Fund for Agricultural Development (IFAD).

In Haiti, a national campaign for control of diarrhoeal diseases and improvement of child nutrition was launched in mid-1983 with considerable support from private enterprise and from NGOs. ORT and breast-feeding are emphasized, as well as environmental sanitation.

As indicated by these examples, the joint WHO/UNICEF programme is encouraging a broad range of activities suited to local conditions and designed to reinforce each other's impact on children's nutritional status. Broad problems of agricultural production and rural development are not directly addressed by the programme, but JNSP has developed close working relations with IFAD which assists countries in these contexts. □

Home preparation of weaning foods, nutrition education, family health, and child care are among the activities encompassed by the WHO/UNICEF nutrition programme.



Other basic services for children

Safe water supplies and sanitation

UNICEF co-operation in water supply and sanitation programmes around the world in 1983 amounted to nearly US\$68 million, making the financial level of this category of assistance second only to that of child health and nutrition combined.

UNICEF has been closely involved for many years in the provision of clean drinking water and the sanitary disposal of human excreta and other wastes in poor rural and urban communities, recognizing their vital contribution to the control of infection, disease, and malnutrition among young children. Since the declaration by the UN of an International Drinking Water Supply and Sanitation Decade, with its goal of "clean water and sanitation for all by the year 1990," UNICEF has further intensified its efforts to promote the installation of low-cost community systems, empha-

sizing not only the importance of clean water but of water in sufficient quantities for personal and household cleanliness.

UNICEF's sharper focus in the past two years on the health and nutritional status of the very young child has encouraged a strengthening of the links between primary health care programmes and water and sanitation services. In many countries water and sanitation installations, and the health education activities associated with them, are providing a springboard for a full-scale attack on infant and child mortality and morbidity.

In certain projects, the curriculum for village-based workers being trained in association with borehole and hand-pump programmes includes child nutrition and the treatment at home of childhood infections, by oral rehydration therapy for example. The message that safe water, waste disposal, and good health are inextricably linked is constantly reinforced. In Nigeria's Imo State, an immunization programme has recently been grafted onto the water and sanitation project, using the new village-based worker network to reach the maximum number of newborns and infants. This example of integration between water supply and primary health care services is providing a model for project planning and implementation elsewhere in Nigeria. (See profile on page 20.)

In financial terms, the major UNICEF inputs are the provision of high-speed drilling rigs, pipes, and cement for the construction of latrine slabs, catchment tanks, and other installations. However, in 1983 UNICEF made at least an equal contribution toward meeting the goals of the Water Decade by emphasizing training for community personnel and the mobilization of human resources. These have become important elements in almost all country programmes for co-operation in water supply and sanitation services.

A more energetic effort is also being made to identify NGOs involved in water and sanitation programmes and

Spreading the good news about water and sanitation

NIGERIA

For 20 years, no good water had been struck in Ohaozara, a remote area in Nigeria's northeastern Imo State. Then a UNICEF drilling rig came, with a team of expert technicians, and in the words of a local chief: "Good water was struck from the rock to the surprise of all, and people were jubilating."

But in Ohaozara as in other parts of Imo State, where UNICEF is co-operating with government and local communities in a water and sanitation project, striking good water is not the whole story. What is unusual, if not unique, about the project is the way in which health educators are trying to revolutionize people's deepset attitudes about water use and excreta disposal.

Rural water supply projects in developing countries have often been slow to bring about better health. An abundant supply of clean water is vital to good health, but it will be a limited blessing unless it is accompanied by better household and community sanitation.

In each village, the "good news about water and sanitation" is first brought by the project's mobilization team, who encourage volunteers to come forward for training

as village-based workers. A training team follows, then a sanitation team, one of whose concerns is seeing to the construction of pit-latrines. The last team to arrive is the drilling team — the "miracle workers" of the operation — to bore the tubewells and fit the handpumps.

Around six village-based health and sanitation workers — at least two of whom must be women — are chosen from each community. Those selected must be literate, permanently settled, and married, preferably with children. Training lasts 10 weeks — the first two of which are devoted to a residential course, the next seven to "practical" work in the village, and the remaining week to clarification and follow-up.

Once trained, the job of the health workers is the delicate one of spreading "the news about water and sanitation" by pointing out to their friends and neighbours the dangers to which they are subjecting their families by leaving food-stuffs exposed in the kitchen, water pots with their lids ajar, and by defecating in the bush instead of in a latrine. "It is necessary," says Grace Norman, a health officer, "to persuade people to change their habits".

Although their job is vital, it is by no means easy, involving such problems as infrequent compensation by their villages, local prejudices, and lack of status to influence their neighbours. But in spite of this, there are grounds for optimism. As one village health worker reported: "When I spoke to the villagers about excreta disposal they did not welcome it. I told them: 'If you do your defecation in the bush, a fly will enter your compound and put germs on your food.' Gradually, I think they are beginning to understand. In time I think we can convince them. The people like us; they listen to what we say."

The Imo State project includes an important fact-finding component. "Enumerators" visit the project areas to count compounds, interview heads of households, and find out as much as possible about existing habits concerning water collection and storage, food preparation, and waste disposal. The duties of the enumerators include obtaining stool specimens from primary school children to determine the extent of diarrhoea and parasitic infestation.

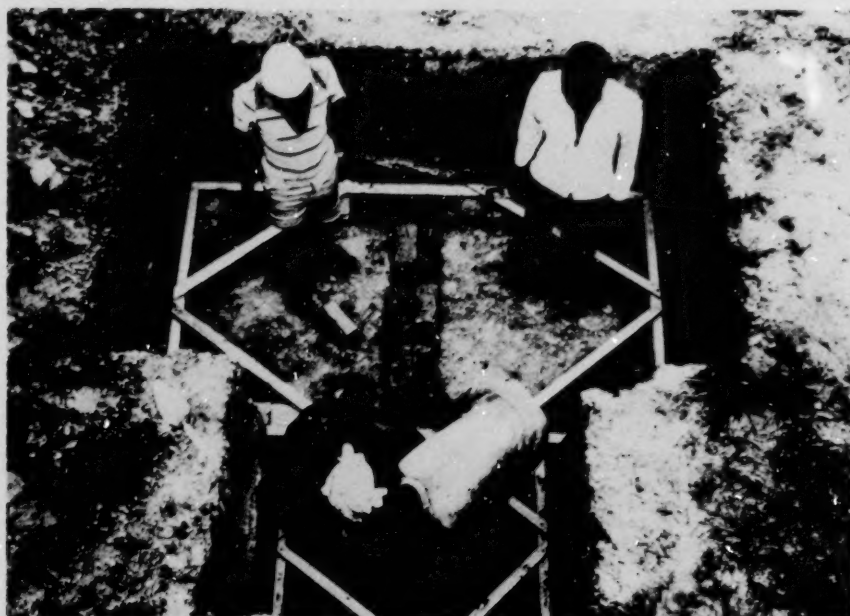
As the project progresses, the enumerators will return to each area to follow up: how have practices changed? Has the rate of parasitic infestation decreased? Has the incidence of cholera and guinea worm (respectively the most feared and the most loathed diseases in Imo) been affected? The answers to these questions should illuminate the project's strengths and weaknesses.

While the US \$250,000 UNICEF drilling rigs provide the drama as they drill through the sandstone to strike clean water, it is the related work of motivation, evaluation, and above all health education that make this a unique water and sanitation project. Over time, if the village-based workers continue their efforts at persuasion and example, a major improvement in children's health is assured.



UNICEF 9370/Black

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Improvements in sanitation for use at village level include the VIP (ventilated improved pit) latrine, here shown under construction in rural Tanzania.

to work in co-operation with them. In Haiti, UNICEF has brought a number of NGOs into contact with the Service National d'Eau Potable (SNEP), and thereby assisted their drilling operations and handpump installations through UNICEF's own programme of country co-operation. UNICEF also continued to support and participate in the work of regional training institutions, such as the Training Centre for Water Technicians at Wad-el Magboul, near Khartoum.

The need to improve community motivation and the increased importance attached to health education have prompted adaptations of existing training curricula, and an expansion of activities for some community-level cadres. While water supplies are frequently a deeply felt need in third world rural communities, disposal of human wastes is often not perceived as a problem and latrines are rarely greeted with enthusiasm. In many training programmes, therefore, more emphasis is being placed on the ill-effects of inadequate waste disposal, and the need for improved personal hygiene, such as washing hands after defecation and before handling food.

In Pakistan, community motivators are being trained to introduce simple sanitation practices and hygiene concepts along with the construction of latrines. In Nepal, where there seems—

unusually—to be a real demand for sanitation at village level, teaching materials on sanitation have been developed for use in primary schools. During their annual refresher courses, Nepal's water and sanitation technicians have been taught the use of oral rehydration therapy for diarrhoea cases, and village tap caretakers have been given vegetable seeds so that they can use the waste water in the tap area to plant vegetable gardens. In Indonesia, UNICEF has assisted in the training of village volunteers in the maintenance of water systems, providing them with tools and spare parts such as washers, nuts and bolts—an approach originally developed some years ago in India.

UNICEF field staff continued to participate in the development and testing of a number of technological innovations, including adaptations of water catchment and gravity-flow systems and better shallow and deepwell handpumps. The considerable support being provided to these technological developments by UNICEF, the World Bank, the UN Development Programme (UNDP) and others has led to a better acceptance on the part of governments of low-cost approaches. The possibility of reaching many more people with installations which do not require expensive maintenance, and which are as effective in meeting com-

munity needs, is gradually proving a persuasive argument in their favour.

Improvements in sanitation technology also met with support during 1983, notably at community level. An interesting feature is the introduction beyond Southern Africa of the ventilated improved pit (VIP) latrine developed by the Blair Institute in Zimbabwe. It is now in use in a number of countries where UNICEF is co-operating in sanitation programmes often in partnership with UNDP and the World Bank.

In spite of the obvious interaction between a safe water supply, proper waste disposal, improved hygiene, and people's health and well-being, it has proved difficult to evaluate precisely the impact of UNICEF-assisted water and sanitation programmes. This problem derives partly from the difficulty of identifying key indicators and measuring them in isolation from influences other than the new water supply or



WATER AND SANITATION: In 1983 UNICEF

- » co-operated in programmes to supply safe water and improved sanitation in 97 countries: 39 in Africa, 19 in the Americas, 30 in Asia and 9 in the Middle East and North Africa region
- » completed approximately 75,271 water supply systems, including 72,919 open/dug wells with handpumps, 661 piped systems, with 435 motor-driven pumps and 1,256 other systems such as spring protection, rain water collection and water treatment plants
- » benefited some 12.9 million persons (40 per cent of them children) from its rural water supply systems
- » completed 312,698 excreta disposal installations benefiting some 2,823,500 people

“We need water, not gold” — BURMA

“We need water, not gold”, reads the notice. It is posted in a village in Burma’s Central Dry Zone, a vast area in this otherwise well-watered country characterized by seasonal stream beds, dry bush and dust. Occasional green paddy fields, a stark contrast to the surrounding aridity, show what can be done when water is available. It is to address this urgent problem that UNICEF, in co-operation with the Australian Development Assistance Bureau, is assisting the government’s rural water supply project in the Dry Zone.



ICEF 9373/Lhapungha

Since 1978, some 1,800 tubewells have been drilled, with 3,200 more to be completed by 1986. The big Failing Rigs provided by UNICEF briefly dominate the scene in the villages in which they operate. But village co-operation is

necessary to make the project a success. While the tubewell is provided free, villagers must run and maintain the pump and provide all labour and costs for the storage tank and pump house. According to one village chairman, each family pays what it can afford. Well-to-do donors are willing to meet additional expenses because they feel that giving water is as meritorious as putting an umbrella on a pagoda, long regarded in Burma as one of the crowning acts of Buddhist piety.

In communities where the villagers have played their part and where the problem of sanitation has also been addressed, health benefits are already observable. In Kyunbobin village, for example, a tubewell was drilled in 1980, and there is little evidence now of trachoma and other eye diseases that plague children elsewhere. The village’s energetic Health Officer explains that the community also benefitted from a UNICEF-assisted pilot project to install improved sanitary pit-latrines. The combination, he says, has brought about a significant drop in the incidence of gastro-intestinal disease, and a dramatic decline in the level of worm infestation among children.

In nearby Wayaung, the new water supply has also given a boost to the village economy. A producers’ co-operative using about 700 gallons of water a day and employing 25 villagers, processes the bark of the *thanaka* tree into cakes of a national cosmetic, also called *thanaka*.

Although the Dry Zone has attracted the largest volume of UNICEF assistance in water supply, other areas of Burma have not been overlooked. UNICEF is involved in gravity-flow systems in the hilly regions, rehabilitation of existing water systems in lower Burma, and a country-wide environmental sanitation project.

sanitation facility; and partly from most countries’ lack of human and technical resources for the collection and analysis of water and health-related data. This situation is beginning to change, under the combined impact of bio-medical research, which has made recent advances in identifying particular contamination agents including viruses responsible for diarrhoea; and the extensive experience that has now been gained worldwide in planning and putting in place community water and sanitation services. UNICEF is working closely with WHO, the World Bank and such institutions as the London School of Hygiene and Tropical Medicine to assist in the collection of data and the development of appropriate evaluation techniques. In Burma, Nigeria, and some other countries, UNICEF is participating in health impact evaluations of particular projects, which should provide important insights into how to maximize the impact of water and sanitation programmes on children’s health. □



UNICEF 048/83/Sprague

Water is often a deeply felt need. Improving a well in Tamil Nadu, India.

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Formal and non-formal education

UNICEF's support for basic and primary education focusses on disadvantaged children, specially those in poor families living in remote areas.

greater participation of girls and women in primary education and literacy programmes, and support has been given to special education projects for women in "family life training centres", in countries such as Ethiopia, Haiti, and Chad. Curricula in such centres usually combine skill training for income generation with literacy and domestic activities such as child care and sound nutrition.

Basic education institutions, such as primary schools and literacy centres, inadequate as their numbers are in most developing countries, are still more widely spread than other social services. They can, therefore, make an important contribution towards efforts to promote the health and survival of the young child. Primary schools, for example, with the collaboration of teachers, parents, and students, can promote health consciousness throughout the community, and spearhead campaigns to explain the use and preparation in the home of oral rehydration mixture, for example.

In 1983, as in previous years, UNICEF's support for the extension of primary and basic education focussed on disadvantaged groups such as children of poor families and families living in remote and underdeveloped areas. Improving the quality of instruction was another principal area of educational co-operation. In Bangladesh, Ethiopia, Sudan and Zimbabwe, assistance was given to pre-service and in-service training for primary school teachers. In remote and thinly populated areas of Syria and Indonesia, UNICEF assisted in the development of one-room multi-grade schools. In Ethiopia and Oman UNICEF supported the production of literacy and post-literacy materials, and in Laos, the production and distribution of basic school supplies, such as blackboards and chalk.

Many UNICEF-assisted education programmes, both formal and non-formal, aim to relate the subject matter of basic education directly to the



ICEF 8298 Wolff

While remarkable progress has been made in the spread of educational opportunities for children in the past two decades, the task ahead remains daunting. According to official estimates, 86 per cent of primary age children in developing countries were enrolled in schools in 1980, compared to 60 per cent in 1960; but of these, one in two do not complete the full primary education cycle, and in the poorest regions and communities, the equivalent figure is four in five. The rate of illiteracy for the total population is 40 per cent, while almost half of all women over 15 years of age in developing countries are illiterate.

The low literacy level among women is particularly disturbing because of its negative implications for the welfare of children. It has been consistently found, in countries at all stages of

development, that the higher the level of the mother's education, the lower the mortality rate of infants.

To reach a sustainable level of education, at least four years of primary education, or its equivalent in non-formal education or literacy, is normally necessary. But even women who have participated in a more limited educational experience are more receptive to new ideas, and more inclined to take advantage of health services and programmes designed to improve the welfare and life prospects of their children.

UNICEF's efforts to improve women's access to education are, therefore, included in the range of activities designated as necessary for a child survival revolution. Emphasis within country programmes has been placed on measures that facilitate a

The clay-pot savings scheme

BANGLADESH

The women's literacy programme in Uttapara, a small and relatively inaccessible village in Bangladesh, grew out of what seemed like a casual visit by Ms. Hosneara Minu, a field worker from the Village Education and Resource Centre. VERC was originally started by the Save the Children Fund (USA), and incorporated in 1977 with financial and technical assistance from UNICEF. Dedicated to the principles of self-reliance and voluntary participation, VERC's development workers will wait months, even as long as a year, for the villagers themselves to decide what problems need to be tackled.

At first some villagers thought Mrs. Minu was a government official who had come to assess their households and land. But as she continued to pay the village regular visits, sometimes apparently just to chat, the women began to discuss with her their needs and aspirations.

Most of Uttapara's families are quite poor, and over half of them are landless. One problem many faced was how to provide for the kind of wedding that tradition demands for their daughters' marriages.

"Have you ever thought of starting to save?" Mrs. Minu asked. At first the idea seemed strange. "How do you save?" asked a 35-year-old housewife named Samirunnessa. "Where would I put the money?"

Mrs. Minu explained that she could put aside one *taka* (US 4 cents) each week safely in one of her clay household pots.

After several months, Mrs. Minu suggested to Samirunnessa that she should spread the idea among her friends. Soon she became the leader of a "clay-pot savings group" among the village women.

The next step was the formation of a women's society. VERC sent a group of young people into Uttapara to put on plays and sketches

about village life. One play showed how a women's society enabled its members to earn some money by weaving, sewing, painting, and raising goats. The women of Uttapara then transformed their clay-pot savings group into a proper women's society.

The literacy programme wasn't launched until four years after Mrs. Minu's first visit. By this stage, the village women had come to recognize their need to keep proper records of their money-making activities and their savings.

To write her own name, let alone be able to read, seemed like a dream to Samirunnessa, until the VERC workers staged another drama in Uttapara. This time, they showed how literacy had come to a similar village. Then they took clay letters out of a paper bag. "It's simple. Look at these letters and imitate the shape. That's the first step." After half an hour's discussion, 17 out of the 33 women's group members agreed to join a literacy class.

VERC staff don't like to predict what the next step will be after the literacy programme takes hold. "It's up to the women of Uttapara to decide."

health and welfare of communities. In Kenya, for example, a school radio programme includes a series on basic health measures. And the Kenyan Department of Adult Education has planned a booklet on growth monitoring, oral rehydration, breast-feeding, weaning and immunization for use in the national literacy programme. In Egypt, reading materials on health, hygiene, and nutrition for use in schools and literacy classes have been distributed to rural areas.

In addition to the regular programme, in 1983 the UNICEF Executive Board approved a US\$30 million co-operative programme with UNESCO, to be financed through special contributions, to support universal primary education and literacy, initially in five countries: Bangladesh, Ethiopia, Nepal, Nicaragua and Peru. In approving the programme, the Board endorsed the initiative of UNICEF to collaborate with UNESCO, national governments and others in their efforts to advance towards the goal of "education for all" by the end of the century. Countries to be assisted are low on the developing world's socio-economic scale, with high infant mortality and low per capita income.



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A growing share of UNICEF resources is being devoted to non-formal community activities for early childhood care and education. At the request of the Executive Board, a policy review entitled "Early Child-



EDUCATION: In 1983 UNICEF

- » co-operated in primary and non-formal education in 101 countries: 43 in Africa, 21 in the Americas, 26 in Asia and 11 in the Middle East and North Africa region
- » provided stipends for refresher training of some 78,900 teachers including 50,500 primary-school teachers
- » helped to equip more than 61,900 primary schools, and teacher-training institutions and 500 vocational training centres with teaching aids, including maps, globes, science kits, blackboards, desks, reference books and audio-visual materials
- » assisted many countries to prepare textbooks locally by funding printing units, bookbinding and paper

hood Development" has been prepared for the consideration of the 1984 Executive Board session. The report examines the programme approaches appropriate for the intellectual, social, and emotional development of the young child in the light of experience and knowledge gained by UNICEF and others. It identifies programme actions necessary in different socio-economic situations, building on UNICEF's advocacy of a child survival and health revolution. This policy review is intended to enable UNICEF to help promote the total development of the child during the critical early years. □

Urban basic services



UNICEF 336/83/Sprague

In 1983 UNICEF offices reported an alarming increase in malnutrition among children living in the third world's crowded slums and shanties.

During 1983 UNICEF continued to expand support to community-based activities in the slums and shantytowns of third world cities, according to policy guidelines approved by the 1982 Executive Board. Nearly 50 countries now receive urban basic services co-operation. Priority programme areas include reducing infant and child mortality and malnutrition, increasing women's income-earning potential, providing day-care facilities, improving water supplies and environmental sanitation, and reintegrating abandoned children into society.

In 1975 about 840 million people lived in the urban areas of the developing world. With at least two-thirds of the population increase in the developing countries now taking place in their towns and cities, this figure is expected to rise to more than 2,120 million by the end of the century. Whereas in the 1960s and 1970s, slum and shanty dwellers represented between 30 and 60 per cent of urban populations, this figure now rises as high as 79 per cent in some cities. This steady expansion of urban poverty and squalor is causing dramatic social upheaval throughout the third world, with important consequences for women, children, and family life.

While widescale urban poverty is a familiar phenomenon in Asia and Latin America, the trend is less visible but at least as disquieting in Sub-Saharan Africa. By 2000, Sub-Saharan Africa is expected to be 38 per cent urban, with 59 per cent of population growth occurring in towns and cities. Moreover, these projections do not take into account the continued strife and prolonged drought in many African countries, which are prompting the forced immigration into population centres of large numbers of rural people whose way of life has temporarily, and in some cases permanently, collapsed.

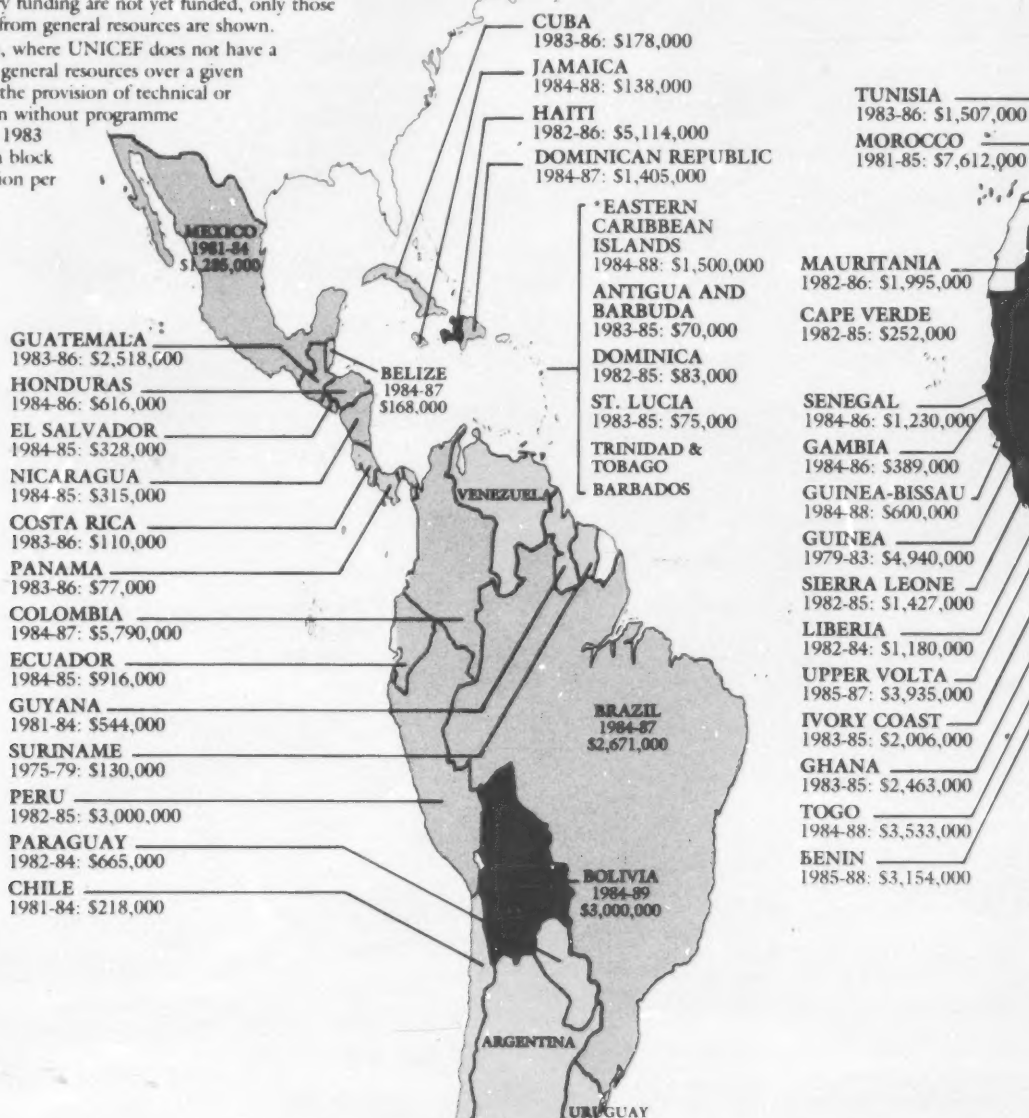
Often as a result of these conditions, UNICEF field offices have reported an alarming increase in malnutrition among urban children. A high proportion of the infants and young children who succumbed last year to a combination of malnutrition and infection died in the slums, shantytowns and infested tenements of the third world. The rural poor can usually depend for their food and shelter on what they can grow or harvest from the land or the sea, but the urban poor depend upon cash. When the economic situation worsens and work is unavailable, there is even less cash than usual, and

UNICEF in action: programme con

The programme commitments shown on this map are for multiyear periods, and are exclusively those from UNICEF's general resources. Those commitments being proposed to the April/May 1984 Executive Board session are shown in colour, and should be regarded as tentative.

In the case of certain countries, particularly those where a special programme has resulted from drought, famine, war or other emergency, the level of already funded supplementary programme commitments is high enough to make a significant difference to the size of the overall programme. However, since many projects "noted" and approved for supplementary funding are not yet funded, only those programme commitments from general resources are shown.

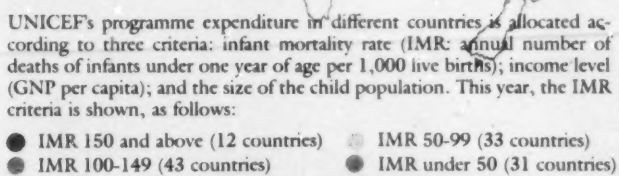
Higher-income countries, where UNICEF does not have a specific commitment from general resources over a given period, but co-operates in the provision of technical or advisory services, are shown without programme amounts or durations. The 1983 Executive Board approved a block commitment of US\$2 million per year for these countries.



Altogether, UNICEF currently co-operates in programmes in 113 countries: 43 in Africa; 33 in Asia; 26 in Latin America; 11 in the Middle East and North Africa.

This map is drawn according to Peters' Projection and the boundaries do not express any opinion of the United Nations.

*Includes St. Vincent, St. Christopher-Nevis, Grenada, British Virgin Islands, Montserrat and Turks and Caicos Islands.



even less food, therefore, for infants and children.

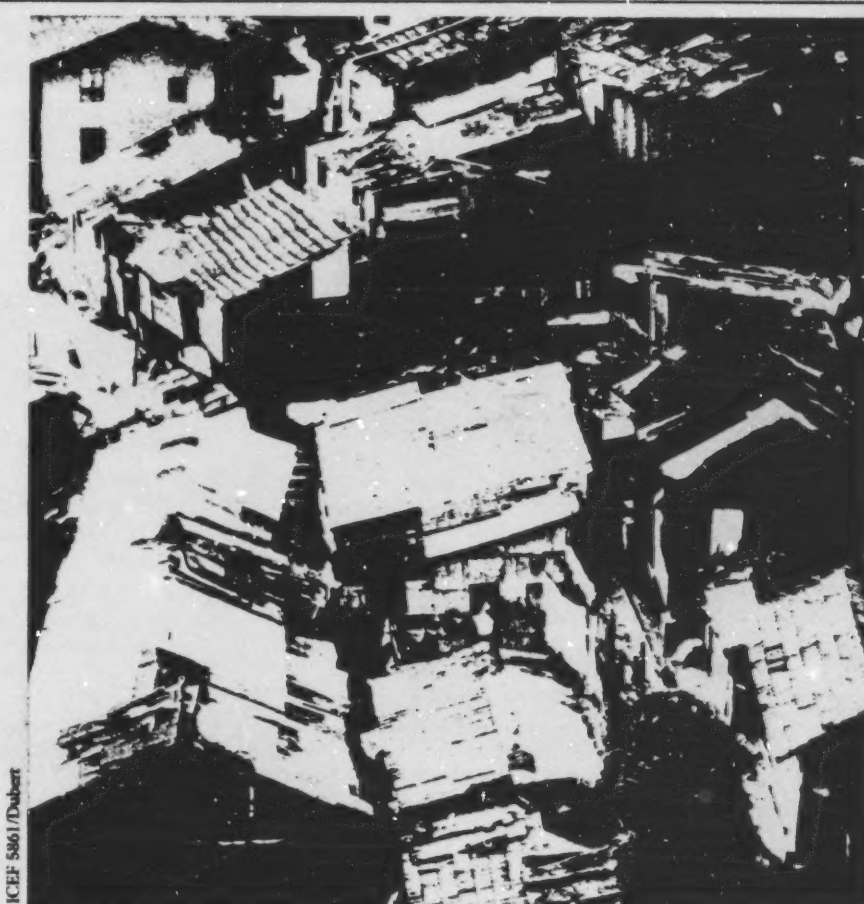
Child malnutrition occurs at an earlier age and is frequently more severe in cities than in rural areas. A contributing factor is the decline in the duration and incidence of breast-feeding. Urban mothers, who are often the only income-earners to support their children, are obliged to take paid employment in circumstances where they cannot be accompanied by a baby at the breast. As a result, the introduction of bottle-feeding, with its attendant hazards of improper dilution and poor hygiene, often takes place at a very early age. A larger set of health problems also contributes to malnutrition in high-density urban areas, where sanitation facilities and refuse disposal services are all but non-existent. Diarrhoea, measles, parasitic infestation, and respiratory infections flourish in these insanitary living conditions.

UNICEF is working with governments and NGO partners to attack unnecessary infant and child deaths, illness, malnutrition and related problems through the primary health care (PHC) framework. UNICEF and WHO have together worked out a programme of joint collaboration for the expansion of PHC services in poor urban areas. In the Philippines, UNICEF is supporting the Davao Medical Foundation in Davao City in a multi-faceted programme to reduce illness and malnutrition. In the light of the number of child minders in slum areas who are themselves children, "child-to-child" instruction is an important feature of the programme.

A recent and dynamic initiative in urban PHC is that taken by the city of Addis Ababa, Ethiopia. The municipality has taken on the challenge of reducing the infant mortality rate (now 150) by two-thirds within seven years. The strategy includes the promotion of breast-feeding, selective supplementary feeding, immunization, and the use of locally-produced oral rehydration solutions. In Peru, UNICEF-assisted primary health care and pre-school services now cover an urban community of 500,000 and include growth monitoring and oral rehydration.

It is estimated that tens of millions of children live without family support. Abandoned children, refugee children, abused children and children working

A sense of comradeship



ICEF 5361/Dahbert

Rio de Janeiro's 1.8 million slum dwellers have a gift for joint enterprise, and enjoyment, despite their life of hardship. At Carnival time, their *samba* bands play a leading role in the city's celebrated festivities.

When Rio's Department of Social Welfare asked UNICEF to help start a basic services programme in Rocinha, the city's largest *favela*, or slum, it was this vitality and sense of comradeship of the slum dwellers themselves that gave the programme much of its promise.

The Rocinha pilot programme, which UNICEF has been supporting since 1979, relies exclusively on community decision-making. With 80,000 people, Rocinha occupies a hillside overlooking the picturesque beach district of São

Conrado. Today Rocinha has Rio's most active community association.

Divided into working committees addressing problems of sanitation, health and education—the community's own priorities—Rocinha's residents have learned how to work with church groups and local philanthropic organizations. They have also learned how to lobby for greater co-operation from the local authorities, such as the city's water, sewage and electric services. According to Rocinha Sanitation Group President, José Martins de Oliveira: "We have learned how to negotiate with the bureaucracy. Now we go to the Municipal Secretariat and we say: 'You give us the material we need and we'll provide the man power'."

BRAZIL

Through such co-operation and a very large measure of self-help, the Rocinha association has launched teacher training and school renovation projects, health information services, and an impressive public health construction programme. The association also sponsors theatre groups, and even a community newspaper. The latest ventures are the rebuilding of a sewage canal and the installation of sewage and garbage collection chutes for residents of the upper reaches of the hillside slum.

Labour is supplied by Brazil's traditional *mutirão*, a community self-help system. "Every Sunday is *mutirão* day," says Adilson Carvalho, who is helping on the new project. "Each person does what he can. The work goes fast, and it's done well." He points to a recently finished concrete retaining wall fitted with plastic drain tubes. "We have a lot of construction workers living in Rocinha," he explains, "and they know what they're doing."

The state secretariat, with UNICEF's assistance, is now extending the Rocinha approach to other *favelas*. One of these is Morro de Dona Marta, another hillside slum. Residents are delighted with their new 7,000 litre water tank, which, with its seven gleaming taps, supplies water to dozens of slum dwellers who would otherwise have to trudge down narrow footpaths to fetch water from the bottom of the hillside. The water tank was installed by people from the community working weekends and holidays, and using materials solicited from local building suppliers.

It was the *favela*'s largest *samba* and carnival organization that mobilized the supplies and man power for the water tank. Now that organizations like this are taking an interest in community projects, the basic services programme in Rio's slums is beginning to march ahead to a *samba* beat.

under intolerable conditions are found in urban areas throughout the developing world. UNICEF's approach to this problem has focussed on backing non-conventional and non-institutional activities for street children and helping governments and voluntary organizations learn from such experiences. In Brazil, a project to help reintegrate street children into their communities was taken up at a much faster pace than had been expected, with over 120 state and local programmes participating. But the problem of how to reach the great number of abandoned and street children in the third world cities still remains an almost overwhelming challenge.

Problems such as malnutrition and abandoned children are closely related to the whole complex of problems faced by the urban poor: housing, sanitation, education, and employment. UNICEF, therefore, continues to emphasize and support multi-sectoral programmes. The urban basic services programme in Mexico, for example, which is being initiated in four pilot communities in the states of Veracruz and Tabasco, includes a core of activities focussed on child health, as well as low-cost water and sanitation technology, housing, food production, and income-generating. Since unemployment and underemployment are so prevalent, small family and community enterprises are being especially encouraged. □



SOCIAL SERVICES FOR CHILDREN: In 1983 UNICEF

- » co-operated in social services for children in 98 countries: 42 in Africa, 25 in the Americas, 20 in Asia and 11 in the Middle East and North Africa region
- » supplied equipment to more than 22,900 child welfare and day-care centres, 22,500 youth centres and clubs and 20,400 women's centres
- » provided stipends to more than 43,300 women and girls for training in child care, homecrafts, food preservation and income-earning skills
- » provided stipends to train some 29,700 local leaders to help organize activities in their own villages and communities
- » provided equipment and supplies to 700 training institutions for social workers, and training stipends for 51,100 child welfare workers

Street children, forced to contribute somehow to their own and their families' survival, are an increasing concern, particularly in Latin America.



UNICEF 177/83, Mera

Women's activities



ICEF 9249 Gubb

An analysis of reports from UNICEF's field offices for 1983 reveals a more profound appreciation of women's multiple roles in programme planning and implementation. As a starting point, some UNICEF offices, notably Oman, Ethiopia, India, and Burma, have initiated situation analyses and needs assessments to help improve the design of programme components affecting or involving women.

The critical role that women play both in the home and the community in the health, nutrition, and well-being of children, has always been recognized by UNICEF. But in recent years there has been a deepening realization of roles other than the domestic and nurturing ones traditionally emphasized.

Support to women's involvement in all aspects of basic health and nutrition remains, however, a central consideration in UNICEF's co-operation in the field of health. Women's full participation is needed to ensure widespread application of the child survival and development techniques identified by UNICEF as crucial to a "revolution" in children's health. Correspondingly, the Joint WHO/UNICEF Nutrition Support Programme (see page 18) includes a dynamic women's component. Activities in three areas will be

emphasized: the protection of women's health and nutritional status during the childbearing cycle; the promotion of women as economically active and independent agents; and the promotion of supportive services, such as day-care, to minimize the effects that increased women's involvement in economic activities might have on child care in the home.

During 1983, a number of steps were taken to consolidate UNICEF support for programmes designed to improve women's income-generating capabilities. Increasing numbers of women, particularly in urban areas, are today playing a vital role, often entirely without support from a male "head of household", in providing for their families. As a result, UNICEF has stepped up its assistance to income-generating activities for women in recent years and tried to shift the focus in these programmes away from handicrafts and piecework, and bring them closer to the economic mainstream.

An important development is the policy of "infiltrating" national level banking systems, to enable women's groups to tap previously inaccessible sources of credit. In Bangladesh, Costa Rica, Colombia and Nepal, UNICEF has helped develop programmes which are integral components of nationwide

Many women in urban areas have to provide for their families without support from a male "head of household". In Zimbabwe, women play a vital role in community projects.

credit schemes and manpower training systems. The problem faced by many women trying to pool their efforts in a small productive enterprise is that they have no banking, credit, business, or management expertise. Skills training, in such circumstances, is not enough. In programmes such as the one in Costa Rica (see profile inset), UNICEF can open up a channel from a much larger source of credit than UNICEF could itself provide to groups of disadvantaged women.

In Bangladesh, working with the Grameen Bank Project, a scheme especially designed to provide credit to the landless, UNICEF helped train 120 women bank workers to decentralize credit services to the village level, and also trained 834 village women group leaders in savings and credit management. To date, under the Grameen Bank's programme, more than 8,000 women's group members have been granted loans to initiate income-generating activities, and their repayment rate has been 99.5 per cent. UNICEF's policy of promoting women's access to credit is continuing to expand through establishing revolving funds within national banking systems.

In many developing countries, women are extremely active in the agricultural sector. UNICEF is therefore supporting women's economic activities in enterprises such as vegetable production, raising poultry, small livestock projects, fish processing, and cattle fattening in many countries, including Egypt, Korea, and Surinam. Fast food and food catering projects have been funded in Ethiopia and Swaziland.

Training activities for women are another key component of UNICEF's efforts to improve the quality of family life. The traditional form of UNICEF-assisted training is that given to women in home economics, health education, child care, and handicrafts. This forms part of country programmes almost everywhere. Training programmes for community workers, extension agents, and women community leaders are most prominent in

Isabel Montes lives in Palmares, a small city in Costa Rica. She shares a house with her mother, who earns a few cents each day sweeping the town square. But Isabel herself has no regular job, and has three small children to support.

When she heard about a group of women organizing themselves because they badly needed to earn some extra income, Isabel joined in the hope of finding some way to feed her little boys. Like many other women's groups in a similar predicament, they turned to a traditional domestic occupation: crocheting. It was not a success.

The group started out in 1981 with 20 members. The idea was that anyone who knew how to do something would teach the rest. One woman knew how to crochet. So they started crocheting blouses which they sold to someone in the export business for US 20 cents each. It was too little, so the women began to look for their own markets.

As Christmas 1982 approached, the women had hopes of selling to shops in Palmares and San José, the capital. They applied to the Banco Popular, where UNICEF has placed funds for urban women's income-generating activities, for a loan of US \$5,000 to buy a year's worth of materials.

Cruz Mary Prado, a Bank employee supported by UNICEF, visited them and recommended a loan of US \$700—just enough for what they thought they could sell that Christmas. The women were very upset at getting such a small loan. But by February 1983, they were grateful to Cruz. Christmas was a disaster. They worked hard, but sold very little.

Isabel Montes and the other women in the Palmares group differ from the vast majority of urban women in Central America mainly in the fact that they are organized. They are typical in that they are poor, easily exploited, and tend to turn to traditional women's activities such as sewing and knitting to

earn extra money.

"We try to discourage women from turning to these female activities as a way of setting up viable businesses", says Athenia Montejo, a UNICEF consultant. "In the long run, it is very difficult for women working by hand or with simple household machines to compete with multinational industries like Textiles de Palmares (a subsidiary of a US garment manufacturer). They should be organizing themselves to produce other goods and services in fields where large firms are less likely to under-sell them."

The fact is that the women of Palmares can't succeed if they don't have a viable business. "They are very determined," Cruz reported, "but they have no quality control. Hand-crocheted goods have a very limited market. The women don't even know what prices to charge because they haven't analyzed their costs. Right now, we're trying to help them get their business on a sound footing."

A few months ago, at Cruz's in-

stigation, the Palmares women met with government agencies who promised to help them by conducting a feasibility study and looking for markets in nearby countries. The Labour Ministry offered to help set up day services for the children.

UNICEF's urban programme in Costa Rica supports groups such as these by helping set up the credit, technical assistance, supply and marketing systems they need to become viable small businesses. Those that have a good chance of finding reliable markets are encouraged to keep doing what they do already. But if—like Isabel Montes and the other women of Palmares—they are competing with larger industries, they may have to be coaxed away towards something more economically practicable.

The important thing about the women's group in Palmares is that they are self-started and self-managing. If they do decide eventually to switch to another product, it will be because *they* have decided there is a better alternative.



ICEF 9329/4/1000

Africa, notably rural extension agents in Ethiopia and home economics agents in Sudan.

A growing category of UNICEF-assisted training is in occupational skills. Of special interest is UNICEF's promotion of women's training in construction-related skills. In Swaziland, where most of the men work as contract labourers in South Africa, UNICEF is supporting training programmes in block-making and welding, which are extremely popular. UNICEF also supports training courses in management and credit for women's co-operatives.

As increasing numbers of women enter the labour force, a higher priority is being attached by many governments to the need for day-care facilities. UNICEF has responded with support for the expansion of creches, kindergartens, and other pre-school facilities in Thailand, Iraq, the Philippines, the Caribbean, and elsewhere.

UNICEF's support for pre-schools, which not only look after the health, welfare, and learning needs of young children, but which provide an entry point for a variety of community services, is exemplified by country programmes in Korea and India. In Korea, innovative day-care centres are linked to an integrated basic services project in underserved areas, and incorporate experimental programmes developed by the Korea Institute of Behavioural Sciences. One of these centres has generated a training programme for unemployed mothers, a job placement centre which bargains for standard wages, and a women's community bank.

In India, more than 40,000 women have been trained to staff community-based *anganwadis* or "child-care courtyards". In addition to pre-school education, these provide supplementary feeding, serve as delivery points for immunization and health check-ups, and promote sound weaning practices and health education to mothers. □

At the National Institute for the Blind in Bogotá, Colombia, Cesar receives special pre-school training. UNICEF encourages the detection and treatment of childhood impairments in the community, and the maintenance as far as possible of the normal cycle of child development. Cesar will soon go to a regular school with sighted students.

Childhood disabilities

In 1983 there was substantial progress in programmes for the early identification and prevention of disabilities among children, and for the rehabilitation of the already impaired. UNICEF's increased emphasis on immunization and other aspects of primary health care was an important contribution toward the prevention of disabilities. But recent research is beginning to confirm that in those countries where there have been recent declines in infant mortality, the prevalence of disabilities tends to increase with the survival of a comparatively higher number of weaker infants. UNICEF expanded its support to the training of mothers and community workers in the early identification of impairments, sponsoring of workshops in Indonesia, Zambia, Sri Lanka and Kenya. Some of these workshops followed up surveys conducted in 1981 during the International Year for Disabled Persons (IYDP), whose results were analyzed in 1982. In Zimbabwe, a national plan based on an IYDP survey is being developed, and legislation has passed for the duty-free importation of equipment for disabled persons.

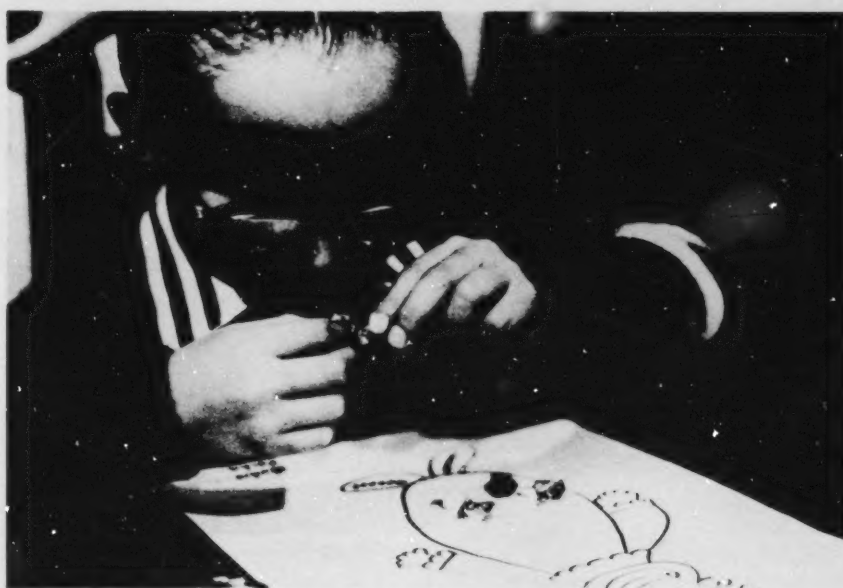
The problem of childhood disabilities in developing countries, though widespread, has not in the past received a very high priority. Advocacy efforts which were launched in 1981

for the IYDP have now led to pilot projects in many countries, and these in turn are leading to wider coverage. In Afghanistan, with UNICEF support, teachers are being trained to detect visual, hearing and other health related disabilities, using materials developed jointly by the ministries of education and public health.

In UNICEF-assisted early education projects in Korea and Thailand, the concept of disability has been extended to include behavioural disabilities resulting from insufficient physical, intellectual and emotional stimulation during the period between birth and six-years-old.

In Indonesia, a two-year project to integrate hearing-impaired children into regular classes was completed in 1983. To complement this, UNICEF is providing financial assistance to a non-governmental organization in Indonesia for a project for blind children and youth in rural areas; the goal is to train these blind children to get about on their own and to develop skills that will enable them to become productive members of their communities.

Rehabilitation International continued to co-operate closely with UNICEF in technical support on the prevention of childhood disabilities and the rehabilitation of disabled children. □



Sushila needs a new kitchen stove

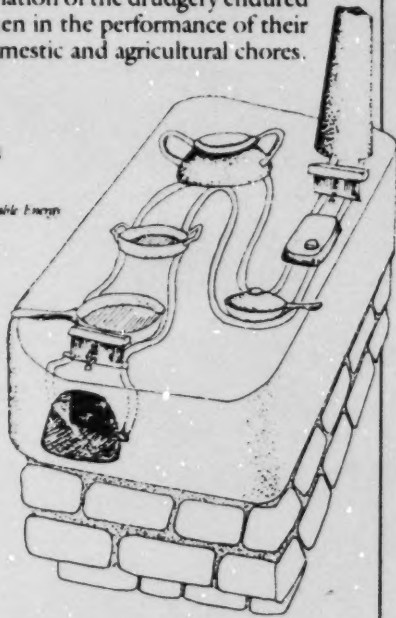
NEPAL

Appropriate technology

Improved low-cost technologies, using skills existing in the community and local or easily obtainable materials, can play an important role in improving the conditions of family life. Fifty-five UNICEF-assisted country programmes now include the application of appropriate technology ideas and devices in health care schemes, food processing, conservation and preparation, water supply and sanitation projects, and in the alleviation of the drudgery endured by women in the performance of their daily domestic and agricultural chores.

Lorena stove

Source: Renewable Energy
Dictionary
VITA, 1982



In recent years, the household fuel crisis in the developing world has given rise to increasing concern. One of rural women's most arduous burdens, which their children help to bear from an early age, is the gathering of firewood. The UN Food and Agriculture Organization (FAO) estimates that by the end of the century three billion people will be living in areas of acute fuelwood deficiency. Concern about the increased time, energy, and costs faced by women in poor societies in meeting their household needs for fuel, led UNICEF to publish a special report in 1983 entitled "UNICEF and the Household Fuels Crisis". UNICEF is now assisting in the development and use of fuel-efficient cookstoves in 24 countries, as well as in the development of bio-gas generators using animal, human and agricultural wastes, and in the planting of community



UNICEF 351/83/McBee

Most of her fellow Nepalese would regard Sushila as a modern woman: she has taken a chance on replacing her traditional cooking stove with an improved model. Like other families, Sushila lives in extreme hardship. Clinging to a steep hillside, the farm provides the most meagre living. They are dependent on a few animals, and on the crops they manage to coax from the narrow terraces of their small plot. Sushila and her children clamber for hours a day over rocky paths to fetch water, fodder, and bundles of firewood. But gathering wood is becoming more and more difficult. Nowhere is the developing world's firewood crisis more evident than in Nepal, where deforestation leads to runaway erosion, landslides and floods.

Nearly every household in Nepal uses wood for cooking, whether on a simple three-stone fireplace, or an elaborate clay-modelled four-burner stove. Most consume wood inefficiently, and also allow smoke to fill the room, creating an environment which has been blamed for many eye and respiratory problems.

Sushila's new stove, an improved "smokeless chula", was recently installed by workers from her village's Small Farm Family Programme. Costing the equivalent of US 75 cents for installation, the stove will save up to 40 per cent of her firewood, and will

leave her kitchen smokeless. It is one of a new prefabricated design made by traditionally trained potters working in several locations around the country.

Fuel-efficient stoves are not new to Nepal, but until recently efforts to introduce them concentrated on training individual families to build their own—a time-consuming and not always successful job. The advantage of the prefabricated model is that the precise dimensions for vents and flues are identical in all the stoves, thus keeping intact the fuel-saving design.

The introduction of prefabricated fuel-efficient stoves into Nepal is being supported by several aid programmes. UNICEF, in collaboration with Nepal's Agricultural Development Bank, has devised a system by which villagers like Sushila can acquire a stove free. A stove costs US \$5 to make, and it is hoped that after the introductory free offer—UNICEF is providing 1,000 stoves over the programme's first year—potters will be able to promote and sell the stoves at this price.

Sushila is pleased that she will no longer need to spend so much time gathering fuel, and that her children will no longer cough. Even though the new model stove is not yet perfect, it is from women like Sushila who use it that the most important suggestions for improvement will come.

woodlots.

Substantial appropriate technology components have now been incorporated in country programmes in Ethiopia, India, Kenya, Senegal, Nepal and Indonesia. In Ethiopia UNICEF is assisting the government's Basic Technology Centre at Burayo, near Addis Ababa, where work is proceeding on fuel-efficient clay stoves, water storage containers, solar cookers, and wheelbarrows. In India, UNICEF is assisting training in rural crafts, and is promoting two types of improved grain storage: a modified version of the traditional mud-brick and plaster bin, and silos which can be fabricated in the villages from galvanized sheets.

In Kenya, where appropriate technology centres established with UNICEF assistance outside Nairobi and in Nakuru provide a resource base, training and outreach covered all parts of the country in 1983. The latest item to gain public response is an insulated version of the popular portable charcoal bucket-stove, designed to facilitate fuel savings. In Senegal, UNICEF has supported the development of power-operated millet grinders and rice threshers which are fabricated in local workshops, and operated and maintained by specially-trained village people.

In Nepal, UNICEF's assistance to appropriate technology activities is coordinated under the Small Farms Family Programme. Low-cost water supply and waste disposal systems are being promoted, and the conservation and storage of food. To lighten the daily tasks of women and girls, improved water mills and cookstoves, bio-gas plants and community woodlots are being introduced. In Indonesia, a UNICEF-prepared report, "Village Technology: a Sourcebook", has been published in Indonesian. Developments cover a wide spectrum, from redesigned child weighing scales to the planting of a type of tree called the *Lantoro* (*Leucaena*) that provides both fodder and fuel, and fertilizes the soil.

In November 1983, a successful workshop was held in Nepal for government officials, UNICEF field staff, and NGOs working in several countries. The workshop paid particular attention to how appropriate technology can be used to reduce infant mortality and improve the health and welfare of children and mothers. □

Programme support activities

Monitoring and evaluation

UNICEF has given increasing attention to evaluative activities as a means of helping countries improve programme implementation and service delivery. These activities include a mix of prospective studies, monitoring, programme and project evaluations, periodic reviews of field co-operation, and programme auditing. Evaluations have been most extensively undertaken in the East Asia and Pakistan region, followed closely by South Central Asia and Eastern Africa.

Progress in this field is still hampered by several constraints. Government officials sometimes perceive evaluation as a fault-finding exercise. Evaluations are frequently couched in very general terms or come too late to be useful, and a major problem remains the lack in many countries of experience and expertise, especially in the processing and interpretation of data.

As part of their regular work, UNICEF field staff invested considerable time in following up on project implementation with their national counterparts. The day-to-day assessment of projects, through numerous field trips and consultations, contributed greatly to project monitoring. There was, in addition, increased at-

tention to the development of improved formal evaluation procedures. To strengthen the evaluation of village water supply and sanitation projects, arrangements were made for UNICEF programme officers and government officials from Ethiopia, Haiti, Pakistan, Sri Lanka and Zimbabwe to attend a special course at the Royal Tropical Institute in Amsterdam. This training, which is being extended to staff involved in the extension of primary health care services, aims to demystify evaluation and strengthen it as a project activity. Also emphasized are practical evaluation techniques for use in countries lacking sophisticated data gathering and analyzing facilities.

Steps were taken at UNICEF Headquarters to establish a global inventory of studies and evaluations. Selected reports have been abstracted and entered into an experimental computerized data base system—a "memory bank" of project experiences. Field offices were asked to try to help government departments improve their use of lessons learned from evaluations to improve programme implementation. UNICEF support to the development of information bases in several countries has contributed to improved programme planning, monitoring and evaluation.

UNICEF field staff follow up on project implementation: with pre-schoolers in Bale, Ethiopia at the new village pump.



UNICEF 083/83/Gubb

Programme support communications

Programme Support Communications (PSC), in the UNICEF context, is the use of development communication techniques, ranging from interpersonal communication to mass media, in support of programmes at all levels.

Field offices in 1983 found increasing opportunities to co-operate with national media to motivate the public in measures needed to reduce infant and child mortality. In Zambia, 13 child-care radio programmes were produced, along with 20 episodes of a radio drama series promoting primary health care. Television films and video tapes to promote oral rehydration therapy and breast-feeding were prepared in Brazil, India, Colombia, and Saudi Arabia. In Lebanon, an integrated mass media campaign, involving TV spots, posters, radio programmes, and newspaper features, was mounted to support a polio vaccination campaign.

The communication component of Indonesia's Family Improvement Programme, primarily directed at pregnant women and mothers of children under five, included posters, press advertisements, and radio spots promoting breast-feeding and regular child weighing; while comic strips, posted on village bulletin boards, encouraged good health and nutrition practices prescribed by Islamic texts.

A number of PSC efforts were directed specifically at policy makers in the developing countries. Publication in India of regional language versions of the 1983 edition of the *State of the World's Children* report extended its reach and increased its impact. In Guatemala, UNICEF produced a slide set in collaboration with the National Commission for Breast-feeding Promotion to orient policy-makers. UNICEF also is helping to highlight what has been learned from the successful Brazilian breast-feeding promotion campaign so that other countries can profit from the experiences.

In many UNICEF-assisted programmes, there is a new emphasis on building up production capabilities for non-formal educational materials and improving the communication skills of government extension and field staff. In Belize, UNICEF supported the training of technicians from the ministries of health and education in the production



The new emphasis is on building up local production capabilities for educational materials. Visual aids reinforce the learning process in a literacy class in Bangladesh.

ICEF 9138/Thomas

of community-level educational materials. In the Yemen Arab Republic, UNICEF supported a workshop for media and health staff on communication support for primary health care. Liberia, with UNICEF assistance, established a health education production unit to produce health booklets and radio programmes. In Kenya, UNICEF supported a six-week training course in communication for women extension officers in agriculture, health and community development. In the Eastern Africa region, UNICEF is financing the production of nine regionally-oriented field manuals on PSC techniques for use in extension training institutions.

Inter-agency collaboration

UNICEF continued to strengthen its links with other United Nations bodies with renewed vigour during 1983. Close working relations with the United Nations Development Pro-

gramme (UNDP) continued in New York and the field, with UNDP being involved in country programmes, previews and reviews. The Joint Consultative Group on Policy, originally comprised of UNDP, the United Nations Fund for Population Activities, and UNICEF, welcomed the World Food Programme as a new member of the group. The special linkage established with the World Bank in 1982 is being strengthened, and all World Bank missions in population, health, and nutrition now collaborate closely with UNICEF field offices for support and follow-up.

UNICEF's long-standing close relationship with WHO was further strengthened in 1983. The Executive Director of UNICEF and the Director-General of WHO had a number of consultations, particularly in regard to the 1984 *State of the World's Children* report, which ensured a consensus and joint action in advocacy for improved child health and survival. Relations with UNESCO, in educational programming, and with ILO, in income-generating activities for women, were also strengthened. □

Advocacy for children

Launch of the "child survival revolution"

At its 1983 session the Executive Board strongly endorsed the heightened importance of UNICEF's external relations activities in both industrialized and developing countries. While advocacy on behalf of children has been an important function of UNICEF since the organization's inception, it has assumed an even larger role since 1979, the International Year of the Child, which helped to create new opportunities for effective advocacy and co-operation with NGOs and other partners.

In a world where economic retrenchment has distracted resources and attention from third world issues, there is a renewed urgency to increase a popular understanding of the needs of children in the developing world and to mobilize public and private support on their behalf.

The Executive Director's 1983 and 1984 *State of the World's Children* reports, which dramatized the possibilities of sharply reducing infant mortality in the developing countries through low-cost measures, struck a responsive chord in the media throughout the world. In addition to echoing the messages on what has become known as the "child survival revolution" throughout UNICEF's own films and publications, a number of collaborative efforts were undertaken to reach wider audiences. The BBC, for example, produced a second "global report" on alternative health systems and devoted one half-hour programme to the techniques of the child survival revolution, as carried out by health *promotores* in Colombia (see profile on page 8). An issue of the International Planned Parenthood Federation's magazine, *People*, was devoted to primary health care expansion at the initiative of, and with financial help from, WHO and UNICEF.

Regional journalists' workshops on "Women, Children and Population", sponsored by UNICEF and the UN Fund for Population Activities and organized by the Press Foundation of Asia, were held in Manila and Jakarta, and included discussion of how devel-

oping world journalists could help further the child survival revolution. In Abu Dhabi, a regional seminar on the role of media in social development and child welfare, attended by 50 journalists and officials from the Arab Gulf, took the 1984 *State of the World's Children* report as its point of departure.

In its review of external relations at the May 1983 session, the Board emphasized the need to extend UNICEF's reach by intensifying joint efforts with other UN agencies, governments, UNICEF's National Committee partners, and its allies in the non-governmental world: national and international voluntary agencies, religious groups, parliamentarians, professional associations, and business groups. Many of these took strong positions on child survival revolution measures, and gave them increased emphasis in their assistance programmes in developing countries.

In 1983, advocacy efforts by UNICEF offices in developing and industrialized countries alike led to several important policy decisions related to child survival. The Government of Bangladesh, for example, formally adopted the International Code of Marketing of Breast-milk Substitutes, and a nation-wide immunization campaign with assistance from UNICEF and the UK Save the Children Fund was launched in Uganda.

In September 1983, the American Academy of Pediatrics adopted a resolution endorsing the child survival objectives and practices advocated by UNICEF and WHO; and at its global meeting in Manila, the International Pediatric Association (IPA) likewise endorsed these measures, calling upon "Regional, National and Local Pediatric Societies, and upon all individual participants, to join in this effort". The IPA also agreed to collaborate on three regional meetings on immunization, oral rehydration therapy and other solutions to the major avoidable causes of childhood mortality and morbidity. To further promote joint action at field level, the NGO Committee on UNICEF called on its 139 members to provide detailed information on their activities in countries preparing programmes for consideration by the Board in 1984 and 1985.

Much of the very encouraging official and public response to the 1983 and 1984 *State of the World's Children* reports in the industrialized countries was due to the work of the National Committees for UNICEF. Along with their fundraising, many of the National Committees engaged in extensive information and education campaigns on the child survival revolution. The Swiss Committee, for example, distributed the reports to leaders of professional, voluntary and religious groups, seeking reaction and support for further dissemination. The United States Committee launched a series of meetings with educators and with NGOs in the USA on child survival and development issues. In November, 27 National Committees took part in an external relations workshop in Rome, the first of its kind, leading to a frank exchange on how best to promote UNICEF's objectives and, through their information and development education activities, to gain support for measures to reduce infant mortality in the third world.

Development education is another important aspect of UNICEF's external relations work, and in partnership with National Committees and other NGOs, UNICEF made considerable progress in 1983 in spreading the message of North-South solidarity in support of the child survival revolution. UNICEF maintained a development education resource centre in Geneva, and its staff participated in numerous workshops and meetings. There was close collaboration with groups in various countries, and UNICEF helped to introduce development education materials into school classrooms.



The Picasso UNICEF Christmas card: a mother breast-feeding her child.

International Youth Year

The UN General Assembly has designated 1985 as International Youth Year with three themes: Participation, Development and Peace. IYY presents an opportunity for UNICEF to promote the participation of youth in development, through "Youth in Service to Children" activities around the world. In anticipation of IYY, the UNICEF National Committees in the industrialized countries are encouraging greater youth participation in fundraising and in advocacy for the child survival revolution. In the developing world, UNICEF field offices will co-operate closely with national IYY committees.

Already, in 1983, a strong coalition was developing between UNICEF and organizations such as the World Scout Bureau, the League of Red Cross Societies, and the World Council of Churches to encourage the participation of youth groups in child survival and development activities during IYY. Youth groups have already co-operated actively with UNICEF at the country level. The Sri Lanka Scouts, for example, have helped install village water pumps, and Scouts from the United Kingdom raised funds to support the project. Examples of the successful mobilization of youth can be found in many developing countries, including Chile, Colombia, Ethiopia, Kenya, Mexico, the Philippines, and Upper Volta.

UNICEF's "goodwill ambassadors" and special fundraising events

Special events, ranging from major galas to popular sports events, continued to play an important role in UNICEF's information and fundraising. 1983 marked the 30th anniversary of Danny Kaye's voluntary help for UNICEF. Active as ever, he visited Canada, Denmark and Finland and spoke as UNICEF's Goodwill Ambassador at events in the USA.

Liv Ullmann visited the Philippines, Colombia and Ecuador, and partic-



Liv Ullmann, UNICEF's Goodwill Ambassador, spending time with a family in a poor urban neighbourhood during her visit to Colombia.

ipated in UNICEF benefits in Australia, North America and Europe. In Canada she briefed the press on the 1984 *State of the World's Children* report, speaking out as effectively as ever on behalf of mothers and children in the developing world. Her television appearance in the Federal Republic of Germany alone resulted in more than a million dollars in donations.

Peter Ustinov filmed Greeting Card spots in four different languages. Pelé, David Frost, John Denver, Catarina Valente, Malini Fonseka, Carola Häggkvist, Corrine Hermès, Ravi Shankar and Ben Kingsley also made important appearances for UNICEF.

Benefit premieres of Sir Richard Attenborough's film "Gandhi" were held in some 30 cities around the world, raising more than US\$750,000 for UNICEF's assistance programmes.

Photo exhibits on the child survival revolution were shown in Manila, Port-au-Prince, Washington, Brussels, Paris and New York; and a children's art exhibit on the theme "Water for All", resulting from a contest organized jointly by UNICEF and the OPEC Fund for International Development, was shown in New York, Vienna and London. Certain special events, like walks for UNICEF in several European countries and "Take a Child to Lunch" in Canada, have become an annual tradition for many UNICEF National

Committees. In the Sudan, the Supreme Council for Sport and Youth established the UNICEF Soccer Cup as an annual event for advocacy and fundraising.

The UNICEF greeting cards again brought pleasure to millions of people in all walks of life, providing a major vehicle for bringing UNICEF's name before the public eye, bringing a sense of reward to all those on its volunteer sales networks. The Greeting Card Operation has now embarked on a large-scale promotional campaign in support of the child survival revolution. The first theme card, a Picasso painting of a mother breast-feeding her child, is going on sale in packages of ten with a message on breast-feeding. In the 1983/84 season, messages on the child survival revolution were included in boxes of year-round note cards, and the message: "Spread the Word: Join the Child Survival Revolution", is featured on thousands of sticker-sheets and shopping bags.

UNICEF's Special Envoy

1983 marked the fourth year since HRH Prince Talal Bin Abdul Aziz Al Saud undertook his mission as UNICEF Special Envoy, in the service of children throughout the world. He

continued his strenuous and dedicated efforts, carrying his message on the crucial development aspect of UNICEF's work to leaders and decision-makers in the Philippines, Bangladesh (his second official visit), the Maldives, Sri Lanka, Portugal, Sweden and Spain. He also made three tours in the United States, visiting eight major cities, generating widespread discussion and broad media coverage of the needs of third world children and UNICEF's efforts to meet those needs.

In recognition of his work on behalf of the world's children, the Government of France named HRH Prince Talal "Grand Officier de la Légion d'honneur" on 23 September 1983.

HRH Prince Talal Bin Abdul Aziz Al Saud, UNICEF's Special Envoy, undertook a second mission to Bangladesh during 1983, and is pictured here with children in Dhaka.



UNICEF 349/83/Khan

AGFUND

The Arab Gulf Programme for the United Nations Development Organizations (AGFUND) was formally established in April 1981 on the initiative of HRH Prince Talal Bin Aziz Al Saud, who was elected President of the Programme. Its Administration Committee – composed of representatives from the seven member states of Bahrain, Iraq, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates – convenes regularly to consider project proposals and to decide upon the allocation of funds and the timetable of fund disbursement.

AGFUND is the only institution world-wide to channel all its assistance through the United Nations – and particularly UNICEF – specifically for social development programmes.

Despite the prevailing difficult international situation and significantly lower oil revenues, AGFUND member states demonstrated again in 1983 their commitment to the social development work of the United Nations.

Activities benefiting from AGFUND's assistance cover countries throughout the developing world and include projects in water, sanitation, health, education, food and agriculture, environment, women's devel-

opment, and childhood disabilities.

Contributions to UNICEF through AGFUND and its member states, and through the auspices of AGFUND, from the time of AGFUND's inception in 1981 until the end of 1983, are shown in the following table.

Other benefiting agencies of the UN system are FAO, UNDP, UNEP, UNESCO, WHO, and the UN Trust Fund for the International Year of Disabled Persons.

In addition to AGFUND's success in channelling contributions from its member states to UN organizations, the Programme has been instrumental – through its direct and indirect auspices – in raising funds exclusively for UNICEF from other governments and private sources. Above and beyond its funding role, AGFUND has also been effective in further focussing the attention of governments and individuals upon the development activities and achievements of the United Nations system with special emphasis on UNICEF.

Though AGFUND's member states are still in the process of establishing and strengthening their own social service infrastructures, their genuine concern for the whole of the developing world is reflected in the world-wide scope of assistance and in the broad spectrum of development projects. □

AGFUND Contributions to UNICEF

AGFUND Fiscal Years	1981/82	1982/83	1983/84 to date*	Total to date
<i>US \$ millions</i>				
AGFUND member states	25.0	21.9	12.0	58.9
Other Governments through auspices of AGFUND	8.7			8.7
Private contributions through auspices of AGFUND	4.0	0.1	6.0	10.1
	37.7	22.0	18.0	77.7

*Further contributions for fiscal year 1983/1984 are expected.

Emergency relief and rehabilitation

Disaster assistance

In 1983, UNICEF provided emergency assistance to 29 countries. Fourteen of these were in Africa, where devastating drought struck countries extending southwards from Ethiopia to Mozambique on the continent's eastern seaboard, and from Cape Verde to Angola in the west. In most countries, UNICEF was a close partner with other UN organizations, with the International Committee of the Red Cross, the League of Red Cross Societies, various bilateral aid agencies, and a wide spectrum of non-governmental organizations. In general, UNICEF focussed on the restoration of normal living conditions and services for mothers and children, linking these efforts wherever possible with the strengthening of ongoing child survival and nutrition programmes including nutrition surveillance and oral rehydration therapy.

In Lebanon, which was the scene of UNICEF's largest relief effort in 1982, the UNICEF reconstruction programme continued in 1983, along with the procurement and distribution of relief supplies—blankets, soap and foodstuffs, for example—as new fighting broke out. To combat diarrhoeal disease and dehydration, packets of oral rehydration salts, along with information materials in Arabic, were widely distributed to hospitals, health centres and mobile clinics. Continuing its assistance to water supplies, UNICEF helped the government repair 14 damaged water mains in west Beirut and the city's southern suburbs. In the southern part of the country, UNICEF engineering staff were deployed in Qana, where they continued to help with the major UNICEF/Government of Lebanon programme for the rehabilitation of schools, water supplies, and other services.

A woman and her two children, beneficiaries of a feeding programme in Uganda. She carries the charts on which her children's nutritional recovery is being recorded.

The emergency in Africa

Seventy-three per cent of the funds released from the Executive Director's Emergency Reserve Fund went to Africa. In Ethiopia, UNICEF allocated US\$310,000 in March for medicines, blankets, clothing, and transport for

food and relief supplies. Another US\$200,000 was made available in October for a pilot project carried out in collaboration with the Ethiopian Relief and Rehabilitation Commission and the Catholic Secretariat in Addis Ababa. Under this scheme, assistance was provided to some of the most destitute victims of the drought to buy food, seeds, draught animals, fodder



UNICEF 190/83/Heiden

Seeing it coming just wasn't enough

Many African countries are stricken by severe drought every few years according to a cyclical pattern, and with drought comes the threat—and sometimes the reality—of famine. In 1973 and 1974 a devastating drought cut a broad swath across the continent; and in 1983 the pattern manifested itself again, with 22 African countries on FAO's "Food Alert" list.

In 1973 the drought brought famine to Ethiopia. The feudal regime of Emperor Haile Selassie failed to appeal for international relief until hundreds of thousands of people had died, a failure which eventually cost the Emperor his throne. To ensure that no repetition of this tragic loss of life should ever occur, Ethiopia's new revolutionary government instigated an early warning system, gathering and analyzing rainfall and crop reports from around the country.

In early 1983 it became clear that a serious food emergency was imminent in the northern, famine-

prone part of the country, and the government appealed for international assistance. Aid on the massive scale which the impending emergency warranted was, however, not forthcoming. By mid-year, drought and famine were estimated to have affected over three million people.

Reports from the relief camps in the northern provinces of Wollo, Tigre, Gondar, and Eritrea echoed the heartbreaking accounts of the 1973 emergency. "A family of six arrived at Ibbat shelter in Gondar, after having walked for over six days. The oldest boy, 14, had been suffering from severe malnutrition—he was skin and bones put together. He could hardly look up. Neither could he eat whatever was set before him. The father and two of the children shortly died."

There were many other tragic accounts from the relief workers at Ibbat. "One woman in her late twenties was over three months pregnant when her husband left for an unknown destination to look for food for the family. Months passed; he did not return.

After ten months she left, carrying her new baby on her back, and they found shelter at Ibbat after walking four days. The children's chance to survive is still very shaky and doubtful. We tried to talk to the mother; she could not talk, only cry."

The Ethiopian Relief and Rehabilitation Commission coped as well as it could with the emergency, transferring 100,000 tons of grain from urban distribution channels to feed the affected population, counting on its replacement by international assistance. Canada, the EEC and a few other donors pledged some grain contributions.

In May 1983, UNICEF launched an appeal for US \$3.5 million to finance supplementary feeding for children and mothers, shelter materials, drugs and medical support, as well as water supplies. By the end of November, only US \$596,550 had been received in response to this appeal, and UNICEF added US \$500,000 from its general resources to support



ETHIOPIA

child survival and health activities.

Included was a pilot project to provide families with cash assistance to build up their food reserves by purchase from local markets to tide them over until the 1984 harvest. This scheme was intended, on a small scale, to keep to the minimum the number of families with small children reduced to starvation and forced to leave their homes and trek to the shelters. This cash assistance was provided to families in co-ordination with Ethiopia's Relief and Rehabilitation Commission and the Ethiopian Catholic Secretariat.

UNICEF has liaised closely with other UN agencies, and with the many non-governmental organizations active in relief work. Among those which provided personnel and supplies for the shelter were the Red Cross, Concern, and OXFAM; and many others including CARE, Catholic Relief Services, Save the Children Fund and the American Friends Service Committee, also took part in the overall relief operation.

and other necessities to tide themselves over until they were able to anticipate another harvest. In May, UNICEF appealed for US\$3.5 million in special contributions to finance an extension of its emergency programme, but by the end of 1983, only US\$500,000 had been received. UNICEF committed an additional US\$500,000 from general resources to extend relief and rehabilitation activities as much as possible (see profile on facing page).

In August UNICEF committed US\$400,000 for emergency assistance to Angola. An appeal for a total of US\$4.5 million in special contributions was launched to help 600,000 victims of drought and civil disruption, more than two-thirds of them women and children. Drought began in 1980-82 in the central and southern provinces and continued into 1983. The situation was aggravated by conflict in some areas, resulting in

large-scale population movements. Along with basic shortages of food and medical supplies, there were crippling transport difficulties. The US\$400,000 committed by UNICEF in August helped assure the earliest possible arrival of urgently needed truck spare parts, tools and equipment, basic drugs and soap. UNICEF's logistical and transport assistance was vital in helping to distribute 9,000 tons of food donated by the U.S. government, which began to arrive in September.

In October UNICEF released US\$250,000 from the Emergency Reserve fund for the airlifting of urgently needed drugs to Chad and for buying vehicles for mobile medical teams. This was in direct response to continued drought and the renewal of fighting during the spring and summer, which forced many people to migrate from the northern provinces. Many of these internal refugees had walked for more than 30 days with no belongings and little food. This latest UNICEF action was a continuation of its emergency assistance to Chad, carried out in close co-operation with NGOs such as Médecins sans Frontières and the League of Red Cross Societies. In addition, UNICEF worked closely with a medical mobile team from Radda Barnen, Sweden (Save the Children). For several years the UNICEF programme has supported supplementary feeding, medical assistance, and logistics.

The impact of the African drought on child survival and health was clearly apparent in Mozambique, where UNICEF committed US\$160,000 to airlift medicines and medical supplies. For two years severe drought has been affecting most of the country. A survey in October in one of the hardest hit areas showed high infant mortality rates in the villages. Around 40 per cent of the children under four were suffering from some kind of sickness, and three-quarters of these were suffering from malnutrition and diarrhoea.

By the end of 1983, there were indications that the situation in many parts of Africa was further deteriorating, especially in the Sahel. The Secretary-General of the United Nations launched a campaign to mobilize a major co-ordinated effort by the World Community. UNICEF is participating in the Secretary-General's advisory and working groups on the African emer-

gency, and believes that child survival revolution measures are particularly suited to such emergencies as they have a high life-saving impact at relatively low cost and employ community-based services rather than weighty infrastructures. UNICEF's organizational response to the ongoing emergency in Africa will be the subject of a special paper to be discussed at the 1984 Executive Board session.

Other emergency assistance

Owing to 1983's unusual weather patterns, drought in some parts of the world was matched by disastrous



EMERGENCIES: In 1983 UNICEF

- » assisted 33 countries hit by disasters, 13 in Africa, 8 in Asia, 5 in the Middle East and North Africa, 7 in the Americas
- » expended US\$3 million from the Executive Director's Emergency Relief Fund and channelled special contributions amounting to US\$9 million for shelter, medicaments, water supply equipment, food supplements, and other essentials
- » supported the initiative of the UN Secretary-General in mobilizing extra resources for victims of drought, famine, and conflict in Sub-Saharan Africa; and continued to co-operate in a major UN programme in Lebanon
- » provided relief for earthquake victims in Colombia; for mothers and children dislocated by drought and conflict in Ethiopia; and to contain epidemics of meningitis in Nepal

floods in others. Two emergency grants were made to Nepal, totalling US\$130,000. The first, in May, was for medical supplies airlifted to counter an outbreak of meningitis in the heavily settled Kathmandu Valley, where the Government was forced to close all the schools. The second, in September, was for emergency flood relief in the far west of Nepal, where floods and landslides due to heavy rainfall damaged houses and food stores, disrupted communications, and led to heavy

crop loss. UNICEF provided immunization supplies, general medical supplies, tarpaulins, and blankets, arranging for them to be flown to the devastated area by chartered light aircraft.

The deviation of the Humbolt current off the west coast of South America caused torrential rainfall in northwest Peru, severely damaging drainage and sanitation systems. Fearing a sharp increase in diarrhoeal disease, the Ministry of Health requested UNICEF to provide 100,000 packets of

oral rehydration salts, water treatment supplies, disinfectants and spray equipment. US\$43,500 was committed from the emergency reserve.

In Bolivia, unusual weather patterns led to lowland flooding and highland drought. More than 1.5 million people, including 250,000 children under six, were affected by scarcities of food, clean water and essential drugs. Responding to a special appeal to the United Nations by President Hernan Siles Suazo, UNICEF committed a total of US\$92,500 in emergency assistance. This included funds for food distribution, the purchase of potato seeds, and preparation of meals at education centres and mothers' clubs. Also included was assistance to the construction of windmills in the dry highlands to tap underground water. As part of its support to efforts to reduce Bolivia's high infant mortality rate of 168—the highest, in Latin America—UNICEF provided 200,000 packets of oral rehydration salts.

In close collaboration with the UN High Commissioner for Refugees in Mexico, UNICEF has established health services for children and mothers among Guatemalan refugees in Chiapas. A similar collaboration, aimed at basic education and health services for refugee children in Central America, awaits the commitment of special contributions.

Other assistance provided from the Emergency Reserve Fund in 1983 included responses to floods in Ecuador and Senegal; hurricanes in Fiji and the Comoros; drought in Panama and Cape Verde; earthquakes in Colombia, Guinea and Turkey; a health emergency in Iran; yellow fever epidemics in Ghana and Upper Volta; civil strife in Uganda; refugees in Syria; and social disturbances in Sri Lanka. Early in 1983 UNICEF airlifted US\$305,000 worth of medical supplies to Ghana, Togo and Benin to replenish medical stores depleted by the return of workers and their families who were expelled from Nigeria early in 1983. □



In Mauritania, women and children are the victims of prolonged drought and desertification. Special feeding is provided with UNICEF assistance.

UNICEF's finances: income, commitments, and expenditures 1983-1984

Income

UNICEF's income comprises voluntary contributions from both governments and non-governmental sources. The latter include fund-raising campaigns by National Committees for UNICEF, the sale of greeting cards, and individual donations.

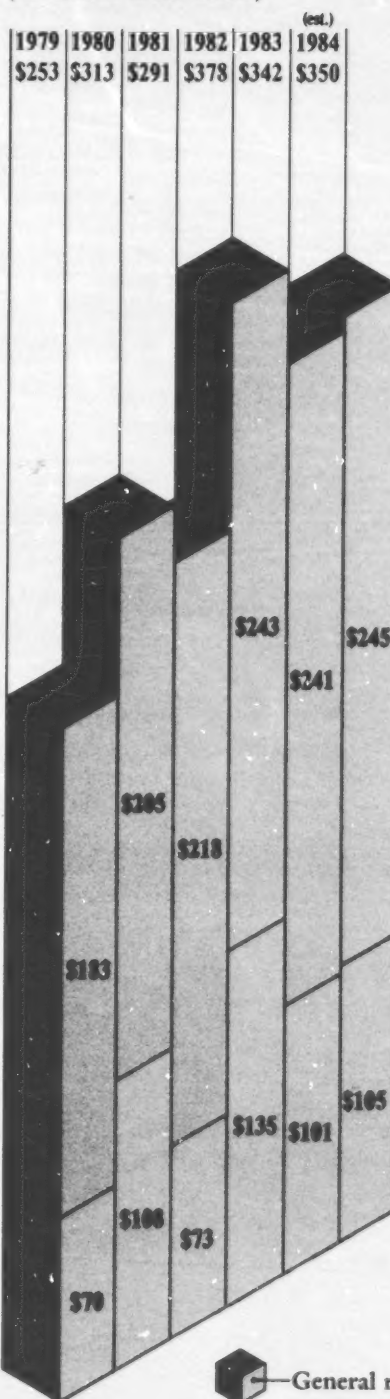
Total income in 1983 came to US\$342 million. This represents a 10 per cent decrease compared to the figure for 1982 (US\$378 million). If the US\$41 million in special contributions made during 1982 for the Lebanon Emergency is excluded, the income level for 1983 was equivalent to that of 1982. Various other factors also contributed to the relatively low level of 1983 income compared to that of 1982. The 1983 figure was depressed by over US\$15 million due to the continuing strength of the US dollar. Furthermore, in spite of increases in contributions by certain major donors, growth in contributions from certain other donor countries has been affected by global recession. Income from governments and inter-governmental organizations accounted for 75 per cent of UNICEF's total income in 1983, with non-governmental income accounting for 25 per cent. The pie charts on page 46 show the division between governmental and non-governmental income for the years 1979 and 1983. The map on pages 44 to 45 shows individual governmental contributions by country for 1983; a list of non-governmental contributions by country appears on page 46.

UNICEF's income is divided between contributions for general resources and contributions for specific purposes. General resources are the funds available to fulfill commitments for co-operation in country programmes approved by the Executive Board, and to meet programme support and administrative expenditures.

General resources include contributions from more than 150 governments, the net income from the Greeting Cards Operation, funds contributed by the public mainly through National Committees, and other income.

UNICEF Income 1979-84

(In millions of US dollars)



Contributions for specific purposes are those sought by UNICEF from governments and intergovernmental organizations as supplementary funds to support projects in the developing world for which general resources are insufficient; or for relief and rehabilitation programmes in emergency situations which by their nature are unpredictable.

As illustrated on the bar chart on this page, about 30 per cent of UNICEF's total income over the period 1979-1984 was contributed for specific purposes.

Projects funded by specific purpose contributions are normally prepared in the same way as those funded from general resources. Most are in countries classified by the United Nations as "least developed" or "most seriously affected". The 1983 session of the Executive Board undertook a review of supplementary funding, and asked that a report be submitted to the 1985 session identifying costs associated with specific purpose contributions and detailing guidelines for their use.

As a result of pledges at the United Nations Pledging Conference for Development Activities in November 1983, and further pledges made subsequently, UNICEF's income for general resources in 1984 is expected to total US\$245 million. Some of the larger increases pledged so far are from Finland, Federal Republic of Germany, France, Italy, Norway, and USA. Certain governments have yet to pledge.

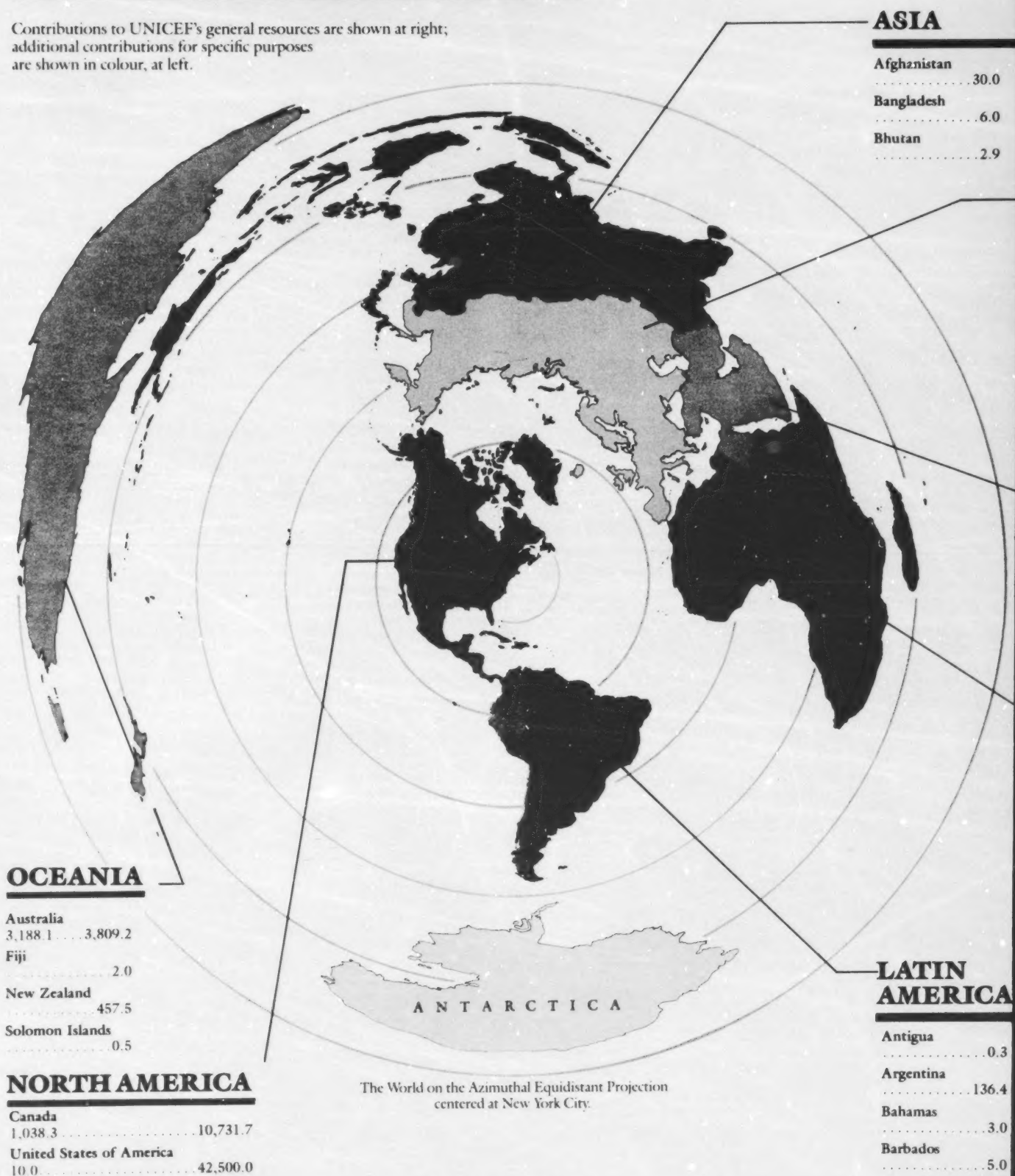
The 1983 Executive Board approved the allocation of funds to support programme activities directed at IMR (infant mortality rate) reduction, and also encouraged specific contributions for these activities.

Expenditures

The Executive Director authorizes expenditures to fulfill commitments approved by the Board for programme

1983 governmental contributions (in thousands of US dollars)

Contributions to UNICEF's general resources are shown at right; additional contributions for specific purposes are shown in colour, at left.



Burma	204.1	Hong Kong	17.3	Japan	10,421.4	Malaysia	184.3	Pakistan	113.8	Sri Lanka	9.8
China	300.0	India	1,814.5	Lao, Peoples Democratic Republic of	5.0	Maldives	3.0	Philippines	496.5	Thailand	292.4
Cook Islands	0.6	Indonesia	557.7			Mongolia	3.6	Republic of Korea	147.0	Viet Nam	4.9

EUROPE

Austria	476.4	758.9	European Economic Community	2,764.6	Germany, Federal Republic of	1,332.4	4,815.7	Italy	18,108.5	16,116.4	Norway	4,107.8	16,617.1	Sweden	7,171.8	19,443.5
B.S.S.R.	78.1		Finland	515.0	3,606.2	Greece	135.0	Liechtenstein	2.0		Poland	78.9		Switzerland	4,147.7	3,969.4
Belgium	354.4	890.6	France	4,183.0		Holy See	1.0	Luxembourg	15.5		Portugal	1.5	15.0	Ukrainian S.S.R.	153.7	
Bulgaria	50.8		Germany, Democratic Republic of	116.7		Hungary	21.1	Malta	4.8		Romania	10.8		U.S.S.R.	843.7	
Czechoslovakia	81.0					Iceland	12.1	Monaco	3.6		San Marino	1.4		United Kingdom	14.6	9,178.0
Denmark	14,007.4	5,180.0				Ireland	344.4	Netherlands	2,978.5	7,862.5	Spain	282.7		Yugoslavia	205.4	

MIDDLE EAST

Arab Fund for Economic and Social Development (AFESO)	106.3	Bahrain	15.0	Israel	50.0	Oman	50.0	Syrian Arab Republic	25.6	United Arab Emirates	694.6
Arab Gulf Fund	1,882.0	Democratic Yemen	6.4	Jordan	27.4	Qatar	200.0	The Opec Fund	635.0	Yemen	14.4
	12,719.0	Egypt	77.3	Kuwait	200.0	Saudi Arabia	1,000.0	Turkey	151.8		
				Lebanon	50.0						
				7,264.9							

AFRICA

Algeria	142.5	Djibouti	2.0	Lesotho	2.5	Nigeria	402.7	Swaziland	6.0	United Republic of Tanzania	23.4
Angola	10.2	Ethiopia	49.8	Liberia	20.0	Rwanda	4.0	Tunisia	44.2	Upper Volta	1.8
Benin	8.8	Gambia	2.8	Libyan Arab Jamahiriya	9.2	Senegal	2.9	Uganda	1.5	Zambia	54.5
Botswana	9.2	Ghana	21.0	Malawi	3.9	Somalia	3.5	United Republic of Cameroon	66.9	Zimbabwe	26.0
Burundi	3.0	Ivory Coast	23.7	Morocco	100.0	Sudan	32.1				
Congo	16.1	Kenya	19.3								

Belize	0.5	British Virgin Islands	0.2	Costa Rica	21.9	Ecuador	51.1	Jamaica	5.5	St. Christopher-Nevis	0.8
Bolivia	16.0	Chile	150.0	Cuba	117.4	Guatemala	53.4	Mexico	136.9	Trinidad and Tobago	10.4
Brazil	100.0	Colombia	396.9	Dominica	1.5	Haiti	11.8	Panama	44.0	Venezuela	199.7
				Dominican Republic	20.0	Honduras	20.0	Saint Vincent and the Grenadines	0.8		

1983 non-governmental contributions (in US dollars)

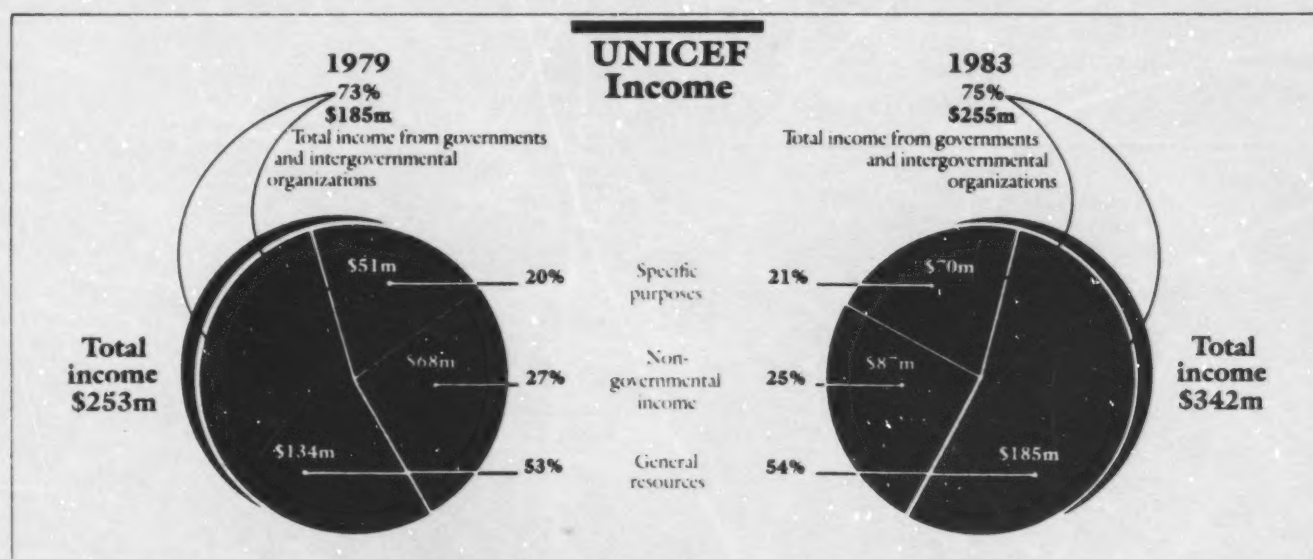
Countries where non-governmental contributions exceeded \$10,000 (figures include proceeds from greeting card sales)

Algeria	154,798	German Democratic Republic	83,513	Netherlands	3,773,337
Angola	52,932	Germany, Federal Republic of	12,438,181	New Zealand	153,468
Arab Gulf Fund	6,051,323	Ghana	141,712	Nigeria	256,948
Argentina	107,013	Greece	242,438	Norway	696,065
Australia	838,271	Guatemala	19,094	Pakistan	46,059
Austria	578,030	Guinea	13,663	Panama	19,651
Bahrain	33,375	Guyana	20,529	Paraguay	37,745
Bangladesh	20,323	Hungary	57,604	Peru	136,125
Belgium	1,142,085	India	740,022	Philippines	49,219
Bolivia	11,329	Indonesia	35,082	Poland	598,388
Brazil	1,621,175	Iraq	44,436	Portugal	47,198
Bulgaria	447,693	Ireland	131,328	Qatar	16,226
Canada	9,515,602	Italy	2,590,635	Republic of Korea	16,623
Chile	118,671	Ivory Coast	27,961	Romania	28,971
Colombia	143,598	Japan	2,735,898	Saudi Arabia	77,021
Costa Rica	22,703	Kenya	28,421	Senegal	24,949
Cuba	45,951	Kuwait	15,937	Singapore	14,079
Cyprus	11,700	Lebanon	36,421	Spain	1,716,188
Czechoslovakia	102,346	Liechtenstein	48,077	Sri Lanka	16,358
Denmark	665,488	Luxembourg	106,595	Sudan	10,179
Dominican Republic	33,333	Malaysia	31,539	Sweden	1,012,035
Ecuador	28,899	Mexico	55,826	Switzerland	3,870,562
Egypt	33,368	Monaco	13,973	Thailand	50,347
El Salvador	10,525	Morocco	34,542	Trinidad & Tobago	13,668
Ethiopia	17,228	Mozambique	34,954	Tunisia	12,471
Finland	1,544,735			Turkey	99,957
France	7,059,371			United Arab Emirates	35,029

assistance and for the budget. The pace of expenditure on a country programme depends on the speed of implementation in the country concerned.

In 1983, UNICEF's total expenditures amounted to US\$332 million. Of this total, expenditures for programmes came to US\$246 million:

US\$98 million in cash assistance for training costs and other local expenses and US\$148 million for supply assistance. The cost of programme support



UNICEF Expenditures 1979-84

(In millions of US dollars)

United Kingdom of Great Britain and Northern Ireland	860,826
United Republic of Tanzania	81,359
United States of America	10,701,272
Uruguay	87,469
Venezuela	14,188
Yemen	20,590
Yugoslavia	379,296
Zambia	33,724
Contributions under \$10,000	214,104
TOTAL	75,361,940

Less costs of
Greeting Card
Operations* (15,871,044)

Net available for
UNICEF assistance 59,490,896

* Costs of producing cards, brochures,
freight, overhead.

services was US\$45 million and other administrative costs amounted to US\$41 million.

The bar chart on this page shows expenditures on programme assistance for 1979 to 1984. The bar and pie charts on page 48 show programme expenditures by sector from 1979 to 1983, by amount and proportion respectively.

Financial plan and prospects

The difficult global economic situation, whose worst effects are felt among women and children in the developing world, has at the same time reduced the flow of development assistance available to help them.

There has been a dampening effect on UNICEF's own income expectations. Meanwhile, UNICEF is striving to maintain the value in real terms of

its level of resources at a time when the economic and political trend is not flowing in favour of multilateral agencies generally. UNICEF is therefore endeavouring to persuade donor governments at least to maintain their social development assistance, and to increase the level of their contributions to UNICEF in real terms. UNICEF is also encouraging the non-governmental sector, through the National Committees and NGOs, to further expand their important contributions.

At the May 1984 session of the Executive Board, proposals for new or extended multi-year programme commitments in 28 countries will be submitted. UNICEF currently co-operates in programmes in 113 countries. The proposed new commitments total US\$102 million from UNICEF's general resources and US\$59.6 million for projects deemed worthy of support if supplementary funds are forthcoming. Programme commitments from general resources for all the countries where UNICEF co-operates are shown on the map on pages 26-27, which also indicates those countries for which commitments from general resources are specifically being proposed at the 1984 Executive Board session.

A Medium Term Plan covering the years 1983-1987 will be submitted to the Executive Board at its May 1984 session. In view of the decidedly mixed prospects for the world economy, the plan anticipates modest real increases in income through 1987. Growth in expenditures is planned to correspond with the anticipated modest growth of income.

The biennial budget 1984/85

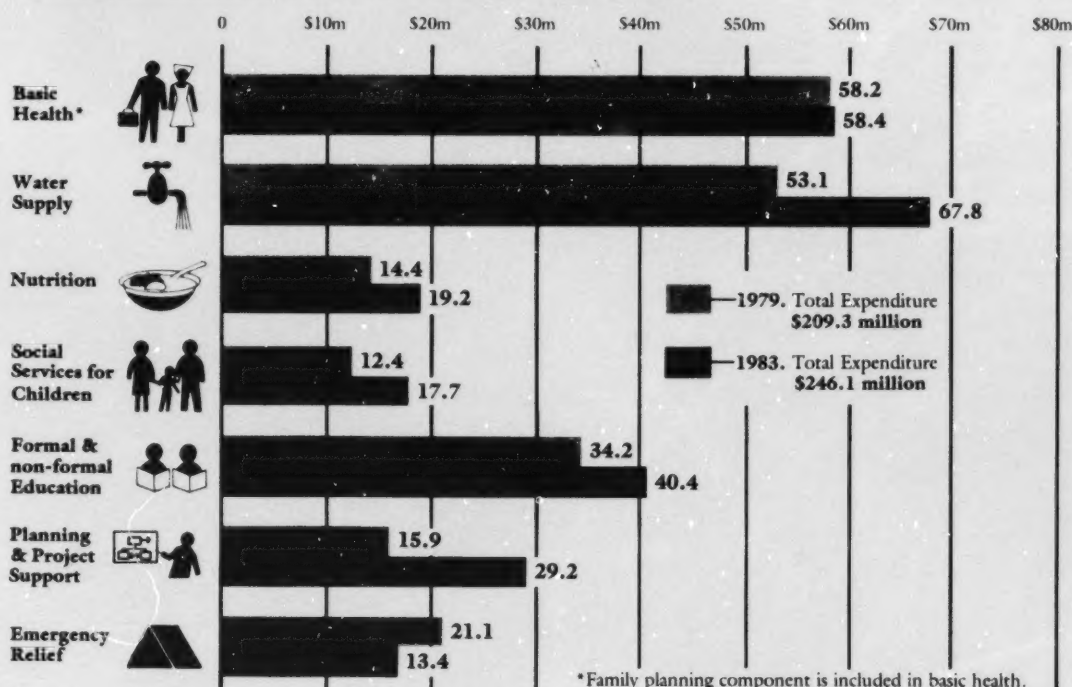
UNICEF is committed to finding cost-effective solutions to programme planning and delivery. Similarly, the organization continues to be committed to finding the most effective and efficient



*In 1982 the definitions for "programme support" and "administrative costs" expenditures were altered

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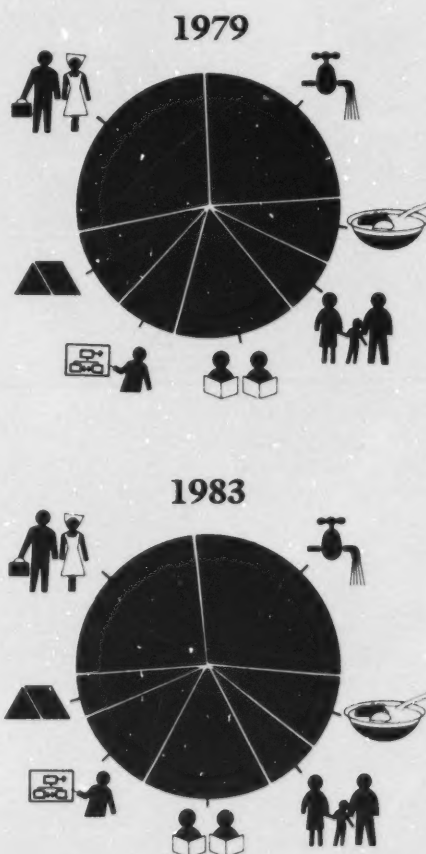
Expenditure on Programmes by Sector



means for using budgetary resources to meet increasing and changing work requirements.

Accordingly, the 1984/85 budget for programme support services and administrative costs at Headquarters in New York and Geneva, as well as in Copenhagen, Sydney and Tokyo, and in UNICEF's 87 field offices around the world, reflected a policy of consolidation and integration. The two-year budget approved by the 1983 Executive Board amounted to US\$218 million: US\$123 million for programme support services and US\$95 million for other administrative costs.

A policy of budgetary restraint and of no overall growth in professional staffing levels has been applied. The consolidation of the UNICEF supply function in Copenhagen has, however, permitted the redeployment of a number of posts to Sub-Saharan Africa. This decision stems from donor governments' perceptions that this is the area of the developing world where women and children are most in need of increased assistance. UNICEF's organizational response to the crisis in Africa is to be the subject of a special paper submitted to the 1984 Executive Board session.



The process of reallocating budgetary resources to countries with high infant mortality rates and weak UNICEF representation is to be continued. These priorities will be reflected in the 1986/87 budget, within the context of a continuing policy of budgetary restraint, designed to ensure that the rate of growth in budget costs does not exceed that of planned expenditure on programmes.

Liquidity Provision

UNICEF works with countries to prepare programmes so that commitments can be approved by the Executive Board in advance of major expenditures on these programmes. UNICEF does not hold resources to cover the cost of these commitments, but depends on future income to cover expenditures from general resources. The organization does, however, maintain a liquidity provision to cover temporary imbalances between income received and spent, as well as to absorb differences between income and expenditure estimates. □

What UNICEF is and does

Origins and current mandate

The United Nations International Children's Emergency Fund (UNICEF) was created on 11 December 1946 by the General Assembly of the United Nations during its first session. In its first years, UNICEF's resources were largely devoted to meeting the emergency needs of children in post-war Europe and China for food, drugs and clothing. In December 1950, the General Assembly changed UNICEF's mandate to emphasize programmes of long-range benefit to children of developing countries. In October 1953, the General Assembly decided that UNICEF should continue this work indefinitely and its name was changed to "United Nations Children's Fund", although the well-known acronym "UNICEF" was retained.

In 1976, the General Assembly proclaimed 1979 as the International Year of the Child (IYC) and designated UNICEF as the lead agency of the United Nations system responsible for co-ordinating support for IYC activities, undertaken mainly at national level. In 1979, at the end of the IYC, the General Assembly designated UNICEF as the primary agency of the United Nations system for IYC follow-up. UNICEF thus assumed the responsibility of drawing attention to needs and problems common to children in developing as well as in industrialized countries. Although this extended UNICEF's area of concern, it did not diminish the Fund's overriding preoccupation with the problems of children in developing countries.

Combining humanitarian and developmental objectives, UNICEF co-operates with developing countries in their efforts to address the needs of children. This co-operation occurs within the context of national development efforts, and its ultimate goal is to enable every child to enjoy the basic rights set out in the International Declaration of the Rights of the Child. Emphasis is placed on the survival and upbringing of children in a family and community environment designed to promote their health and well-being. Recognition is also given to the intrinsic

value of childhood, and to nurturing the imagination and spirit of the child. UNICEF believes that all children should have the opportunity to reach their full potential and, in time, make their own contribution to their country's development and prosperity.

UNICEF is unique among the organizations of the United Nations system in its concern for a particular age-group rather than a particular field such as health or education. UNICEF not only seeks support for its programmes of co-operation, but also tries to increase public awareness concerning children's problems by means of advocacy with governments, civic leaders, educators and the public at large. For this reason, UNICEF places great importance on its relationships with the National Committees for UNICEF and with non-governmental organizations.

Organization

Although UNICEF is an integral part of the United Nations system, its status is semi-autonomous, having its

own governing body, the Executive Board, and a secretariat.

The Board is composed of 41 members who are elected on the basis of annual rotation for three-year terms by the Economic and Social Council (ECOSOC) so as to give "due regard to geographical distribution and to the representation of the major contributing and recipient countries". The membership is constituted as follows: nine members from Africa, nine from Asia, six from Latin America, twelve from Western Europe and other areas, and four from Eastern Europe. The 41st seat rotates among these regional groups.

The Board establishes UNICEF's policies, reviews programmes, approves expenditures for UNICEF's work in the developing countries and for operational costs. The Board meets annually for a two-week main session, and considers programme matters under the agenda of a Programme Committee, and financial and related matters under the agenda of a Committee of Administration and Finance. Reports of UNICEF's Executive Board are reviewed by ECOSOC and the General Assembly.



UNICEF's overriding concern is the welfare of children, who are reached through mothers, community workers, pre-schools and health centres.

UNICEF/341/84/W.011

The Executive Director, who is responsible for the administration of UNICEF, is appointed by the United Nations Secretary-General in consultation with the Board. Since January 1980, the Executive Director has been Mr. James P. Grant.

UNICEF field offices are the key operational units for advocacy, advice, programming and logistics. Under the overall responsibility of the UNICEF Representative in a particular country, programme officers assist relevant ministries and institutions with the preparation and implementation of programmes in which UNICEF is co-operating. In 1983, UNICEF maintained 87 field offices serving 112 countries, with 619 professional and 1,256 clerical and other general service posts.

In 1983, 207 professional and 333 general service staff were maintained in New York and Geneva, to carry out the following functions: service of the Executive Board; policy development and direction; financial and personnel management; audit; information; and relations with donor governments, National Committees for UNICEF, and non-governmental organizations.

Direction of supply matters continues from New York, but by early 1984 most of UNICEF's supply operations will have been transferred to Copenhagen to a new centre which will retain the acronym "UNIPAC" (UNICEF Packing and Assembly Centre), now short for UNICEF Procurement and Assembly Centre.

UNICEF co-operation with developing countries

UNICEF co-operates in programmes in a country only in consultation with the government. The actual administration of a programme is undertaken by the government, and is the responsibility of the government, or of organizations designated by it.

UNICEF gives relatively greater support to programmes benefitting children in the least developed countries. In apportioning UNICEF's limited resources among countries, the 1983 Board decided that the infant mortality rate should also be taken into account as a "guide both to the levels and content of UNICEF programme

In Bhutan, a small boy takes care of his younger brothers on the city streets. The problems of children in poor urban areas are a major UNICEF priority.



co-operation", and this is now one of the principal determinants of the extent of UNICEF country assistance.

The problems of children require a flexible, country-by-country approach, and since no single formula can apply equally to countries at different levels of cultural, social and economic development, with geographic diversities and widely varying administrative structures, UNICEF seeks to adjust the pattern of its co-operation to correspond to regional, national and sub-national variations.

UNICEF co-operation emphasizes programmes benefiting children through improved community and family services; planning and extension of services; exchange of experience among countries; provision of funds for increasing training and for orientation of national personnel; and delivery of technical supplies and other forms of assistance in areas such as water supply, child nutrition, education, improvement of the condition of women and emergency relief and rehabilitation.

Programme co-operation is provided through a number of sectoral ministries such as health, education, social services, agriculture, and those ministries or other authorities responsible for rural, urban, and community development, and water supply and sanitation.

In general, however, problems in

poor communities are usually not perceived or experienced by sector, thus technical support is often needed from several ministries. The problem of child malnutrition, for example, is usually the result of a combination of poverty, inadequate health services, and food shortages; it may also stem from lack of birth spacing, impure water, and rudimentary sanitation, or from improper dietary habits. Since efforts in any one sector may fail if corresponding efforts in others are not made simultaneously, UNICEF recommends a multisectoral approach encompassing both the technical and social elements of programmes.

Basic services

Community participation is the key element of the "basic services strategy" advocated by UNICEF. Of particular concern to UNICEF in recent years has been the continuing high level of infant mortality in many developing countries. Within the framework of basic services, UNICEF is now co-operating with these countries in special efforts to reduce infant mortality through such cost-effective measures as better growth monitoring, oral rehydration therapy, the encouragement of breast-feeding, and universal immunization.

The basic services approach perceives social and economic improvement in low-income rural and urban communities as heavily dependent on the participation of the communities themselves. The role of government, non-governmental organizations and external co-operation is: to stimulate assessment by the community of its children's needs and its agreement to participate in meeting some of them; to strengthen the technical and administrative infrastructure through which family and community efforts can be supported; and to provide through this infrastructure financial and technical inputs, as well as supplies and training opportunities which match the community's capacity to absorb them.

An essential feature of this strategy is the selection by the community of one or more of its members to serve as community workers after brief practical training, which is repeated and extended through refresher courses. To support these community workers, the peripheral and intermediate level government services often have to be strengthened, particularly with para-professionals.

Relations within the United Nations system

UNICEF is part of a system of co-operative relationships linking the various organizations of the United Nations

system. It also works with bilateral aid agencies and non-governmental organizations, recognizing that the effectiveness of programmes intended to benefit children can be substantially increased when a combination of financial resources, and of technical and operating skills is applied to their design and implementation. This system of relationships helps UNICEF avoid spreading its co-operation too thinly among different sectoral concerns in the developing world. Even though in certain countries UNICEF's contribution to a particular problem may be financially modest, its effect can be catalytic, thereby providing a framework for larger-scale co-operation by means of which an approach may be tested and proven before substantial investments are made by other organizations with far greater resources.

Within the United Nations system, collaboration ranges from the sharing of expertise at the country level in developing programmes which require an interdisciplinary approach, to systematic exchanges between organizations on policies and relevant experience. These exchanges occur through the machinery of the Administrative Committee on Co-ordination (ACC), as well as through periodic inter-secretariat meetings held with other United Nations organizations such as the World Bank, the United Nations Development Programme (UNDP), the Food and Agriculture Organization (FAO) and the United Nations Educational, Scientific and Cultural Organi-

zation (UNESCO). Agencies also discuss common concerns through the Consultative Committee on Policies and Programmes for Children, the successor to the interagency advisory group established during the IYC, 1979.

UNICEF's policies for co-operation in country programmes benefit from the technical advice of specialized agencies of the United Nations such as the World Health Organization (WHO), FAO, UNESCO, and the International Labour Organization (ILO). At the country level, UNICEF does not duplicate services available from the specialized agencies, but works with them to support programmes, particularly where ministries such as health and education are involved, and with which the relevant specialized agency works. In addition, the specialized agencies from time to time collaborate with UNICEF in preparing joint reports on particular programme areas. In particular, there is a Joint UNICEF/WHO Committee on Health Policy (JCHP) which advises on policies of co-operation in health programmes and undertakes periodic reviews.

UNICEF co-operates in country programmes together with other funding agencies of the United Nations system, such as the World Bank, the United Nations Fund for Population Activities (UNFPA), and the World Food Programme (WFP). It also works with regional development banks and regional economic and social commissions on policies and programmes benefiting children. Increasingly, UNICEF has sought collaboration with bilateral agencies at field level in order to encourage them to channel more of their resources into programmes which UNICEF cannot fund by itself.

In the case of emergencies, UNICEF works with the Office of the United Nations Disaster Relief Co-ordinator (UNDRO), the United Nations High Commissioner for Refugees (UNHCR), and other agencies of the United Nations system such as the WFP, as well as with the League of Red Cross Societies and the International Committee of the Red Cross.

A young child in N'Djamena, Chad, drinks from a UNICEF pump. A clean water supply, essential to healthy living, is seen as one of the key links in the basic services chain.



UNICEF representatives in the field work with the UNDP Resident Representatives, most of whom are designated by the Secretary-General as Resident Co-ordinators for operational activities. Although UNICEF is not an executing agency of UNDP, it exchanges information with all the agencies involved in UNDP country programme exercises.

Relations with non-governmental organizations

UNICEF has always worked closely with the voluntary sector. Over the years, UNICEF has developed close working relationships with international non-governmental organizations (NGOs) whose work affects the situation of children. Many of these organizations (professional, development assistance, service, religious, business, trade and labour) have become important supporters of UNICEF, by providing a channel for advocacy on behalf of children, and by their participation in fund-raising and other programmes.

National and local NGOs are also playing an increasingly important role in UNICEF's programme co-operation in developing countries in the light of UNICEF's emphasis on community participation in basic services. Many NGOs have the flexibility and freedom to respond to neglected problems, or are represented in remote and deprived areas where either inadequate or no service infrastructure yet exists. Such NGOs can act as vital links between the community and government authorities; and, unlike UNICEF, can work directly with local communities to help them mobilize their resources and plan basic services. In certain situations, NGOs are designated by governments to carry out part of the programmes with which UNICEF is co-operating. Through innovative projects, NGOs can experiment with models for development co-operation which UNICEF and others can subsequently adapt in other areas or undertake on a wider scale.

NGOs also provide UNICEF with information, opinion and recommendations in fields where they have special competence, and in some cases undertake studies on behalf of, or in



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co-operation with, UNICEF. Following one such special study on childhood disability undertaken by Rehabilitation International, an ongoing partnership has developed between the two organizations to reinforce mutual efforts.

As a result of the IYC, many NGOs expanded their activities, including fund-raising and advocacy efforts, on behalf of children. Such has been the scope of their expansion that among them were some organizations not traditionally concerned with children. UNICEF is continuing to foster these relationships (by providing information and by encouraging joint programmes on issues affecting children in developing and industrialized countries) between NGOs, governments and UNICEF.

National committees for UNICEF

The National Committees for UNICEF, normally organized in industrialized countries, play an important role in helping to generate a better understanding of the needs of children in developing countries and of the work of UNICEF. The Committees, of which there are now 33, are concerned with: increasing financial support for UNICEF, either directly through the sale of greeting cards and

Two UNICEF Goodwill Ambassadors cross paths: Peter Ustinov has a word with Liv Ullmann. Both these international stars have immeasurably helped UNICEF help children.

other fund-raising activities, or indirectly through advocacy, education and information.

UNICEF generally receives about a sixth of its income from funds collected by the Committees and from the Greeting Card Operation, for which the Committees are the main sales agents. The increasing activism of the Committees has brought notable results, particularly in fund-raising, promotional and informational activities, and development education. A number of stars from the entertainment world, such as Liv Ullmann, Danny Kaye and Peter Ustinov, have co-operated with the Committees as Goodwill Ambassadors for UNICEF and have raised large sums of money through personal appearances and galas. A number of Committees have been instrumental in attracting wide public attention not only to the "loud" emergency situations affecting children, but also to the "silent emergencies" perennially confronting children of developing countries. In recent years, there has been a closer relationship between the Committees and UNICEF's field operations, with Committee members from a number

of countries undertaking collective study tours to the field to enhance their knowledge of the needs of children in developing countries. An important function of the Committees is advocacy with their own governments for increased assistance to meet these needs.

Greeting cards

UNICEF's popular greeting cards, calendars and stationery items are a significant source of income for the organization's activities on behalf of children: The collaboration of National Committees for UNICEF, NGOs, banks, post offices, business firms, school systems, and co-operatives, to name a few, has made the Greeting Card Operation one of the most successful fund-raising activities around the world. The Greeting Card Operation's unique asset is the opportunity it provides volunteers and the public at large to contribute personally to improving the quality of children's lives through UNICEF. Reproduction rights of the designs are contributed by renowned artists, photographers and leading museums throughout the world.

Funding

All of UNICEF's income comes from voluntary contributions—from governments, from organizations, and from individuals. Most contributions are earmarked for UNICEF's general resources, or they may be allocated to supplementary projects "noted" by the Board for support as resources become available, or for emergency relief and rehabilitation.

Although most of the funding is contributed by governments, UNICEF is not a "membership" organization with an "assessed" budget; it cannot charge governments a share of its expenses. However, almost all governments, both of industrialized and developing nations, make annual contributions, which account generally for more than three quarters of UNICEF's income.

Individuals and organizations are also essential sources of UNICEF's income. In its role as the "people to people" arm of the United Nations, UNICEF enjoys a unique relationship

with private organizations and the general public throughout the world. Public support is demonstrated not only through greeting card sales, but also through individual contributions, the proceeds from benefit events (ranging from concerts to football matches), grants from organizations and institutions, and collections by school children. Often, these fund-raising efforts are sponsored by the National Committees.

developing support from other potential sources.

Information on the funds contributed by the recently created Arab Gulf Programme for United Nations Development Organizations (AGFUND) appears in the main Review chapter of this report. The moving force behind AGFUND is its president, UNICEF's Special Envoy, H.R.H. Prince Talal Bin Abdul Aziz Al Saud of Saudi Arabia. □



ICEF 9266/Thomas

Local institutions are becoming closer partners with UNICEF in the pursuit of child survival and development. Children are brought to be weighed at a health centre in Pakistan.

Despite modest financial resources, UNICEF is one of the largest sources of co-operation in national services and programmes benefiting children. Fund-raising for UNICEF is part of the larger objective of encouraging the greater deployment of resources towards services catering to the well-being of children.

UNICEF's fund-raising strategy aims at meeting the financial projections in its medium-term work plan by actively working to increase contributions from its traditional major donors while

Further information about
UNICEF and its work may
be obtained from:

Denmark:

Finland:

France:

Germany:

Greece:

Hungary:

Ireland:

Israel:

Italy:

Japan:

Luxembourg:

Netherlands:

New Zealand:

Norway:

Poland:

Portugal:

Romania:

San Marino:

Spain:

Sweden:

Switzerland:

Tunisia:

Turkey:

United Kingdom:

United States of America:

Yugoslavia:

Information may also be obtained
from the following Committees
for UNICEF

Australia:

Belgium:

Canada:

France:

Germany:

Greece:

Hungary:

Ireland:

Israel:

Italy:

Japan:

Luxembourg:

Netherlands:

New Zealand:

Norway:

Poland:

Portugal:

Romania:

San Marino:

Spain:

Sweden:

Switzerland:

Tunisia:

Turkey:

United Kingdom:

United States of America:

Yugoslavia:

Czechoslovakia:

Denmark:

Federal Republic of Germany:

Finland:

France:

German Democratic Republic:

Greece:

Hungary:

Ireland:

Israel:

Italy:

Japan:

Luxembourg:

Netherlands:

New Zealand:

Norway:

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